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FEMALE SUICIDAL BEHAVIOUR:
INITIATION, CESSATION AND
PREVENTION

A thesis

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ABSTRACT

This thesis explores non-fatal suicidal behaviour in young women. The approach taken is qualitative in orientation. The central form of data collection was the semi-structured interview. Interviews were conducted with key informants, including counsellors, clinicians and social workers and with women who had engaged in suicidal behaviour. The primary focus of the research was to explore the narratives of women who had engaged in suicidal behaviour, to contextualise their insights, understand their experiences and to examine the meanings of events leading to, and implicated in the recovery from, suicidal behaviour. This material demonstrates the importance of gender in suicidal behaviour and cessation as well as highlighting the limitations of many available therapeutic settings. A key finding of the research is the confirmation of sexual abuse as a common precursor to suicidal behavior, especially when in conjunction with other, mainly familial, risk factors and an absence of protective factors. More significantly, the women noted that the effects of sexual abuse were exacerbated by problems with disclosure. Issues of control emerged as key to both suicidal behaviour and cessation, relating to family circumstance, abuse, disclosure of abuse and efficacy of forms of intervention. In contrast to the literature which suggests that any movement of self-harming behaviours is along a continuum from the less to more severe, the data gathered in this research suggests an episodic, or punctuated, pattern of behaviour, in which the protagonist moves between self-mutilation and suicidal behaviour. These findings problematise the notion of self-mutilation and suicidal behaviour as somewhat distinct behaviours. More generally, the material gathered from the women emphasizes the multi-causal and complex aspects of suicidal behaviour. The complexity of lived experience has implications for effective intervention and prevention strategies. Many of the women stressed the problematic nature of the forms of intervention they were able to access. Indeed, some regarded their experiences of intervention as reinforcing their feelings of lack of control. This was largely confirmed by analysis of the interviews with key informants.

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The production of this thesis has, at times, been a solitary task, and I am appreciative of the encouragement and interest shown by various friends and colleagues along the way, especially Helen Wihongi.

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DEDICATION

This thesis is dedicated to the women who so willingly spoke of their personal experiences so that others could develop a greater understanding of suicidal behaviour.

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INTRODUCTION TO THE ISSUES

This thesis examines the phenomenon of non-fatal suicidal behaviour¹ among young women in New Zealand, from risk factors through to recovery and prevention. Barriers to death are increasingly strengthened through advances in medical science; we are more aware of the causes of premature death than ever before. Yet some young people in New Zealand continue to attempt (and in some cases succeed) to take their own lives. Through this thesis I discuss the experiences of women who have attempted to take their own lives, initially through the perceptions of key informants, then through the first-hand accounts of women who have engaged in suicidal behaviour.

We live in a time in which we have created a vast array of sophisticated technological procedures for 'saving' life yet we have been unable to remove the shadow of the valley of death; if anything the shadow has darkened (McIntosh, 2001, p. 234).

In introducing the topic, this chapter begins by discussing the importance of this area of research, making use of statistics to illustrate the extent of the phenomenon. The problems of definitions in relation to self-injurious behaviour and ethnicity are explored, and operational definitions for 'non-fatal suicidal behaviour', 'Maori' and 'youth' are provided. This introductory chapter is followed by a broader discussion of some of the literature on suicidal behaviour. Overall, the literature on this topic is vast, so, of necessity, the literature review is limited to what appears to be the most salient to the topic of non-fatal suicidal behaviour in young women. Having provided this background information in Chapter Two, Chapter Three discusses the methods used for the conduct of research and analysis in this thesis. The following chapter sets out the data gained from Component One of the research, interviews with key informants. The fifth chapter presents the condensed narratives of the 24 Component Two participants who had engaged in suicidal behaviour, while Chapter

¹ As defined by O'Carroll and colleagues (1998) – see page 9. Unless preceded by the words 'non-fatal', the term 'suicidal behaviour' refers to both fatal and non-fatal behaviour.

Six is an attempt to synthesise these stories, drawing them together into various themes. Chapter Seven discusses the findings of both components of the research, with reference to the pertinent literature, and draws comparisons between the two component groups. Finally, in Chapter Eight, the key conclusions of the research are summarised, limitations of the research are discussed, and possible areas for further research are identified.

Aotearoa/New Zealand has one of the highest rates of youth (ages 15 to 24) suicide in the world. In 2000 (the most recent comparison) WHO data ranked New Zealand second highest out of 23 OECD countries for male youth suicide, with 40 deaths per 100,000 population, while young women had the fourth highest rate (New Zealand Health Information Service, 2002). However, completed suicide is only 'the tip of the iceberg' in suicidal behaviour. The most recent statistics indicate that 198.5 per 100,000 young people were hospitalised for deliberate self-injury in 1999/2000² (Ministry of Health, 2002). Females are far more likely to be hospitalised for intentional self-injury than males, and (arguably) Maori have been more likely to be hospitalised than non-Maori (Ministry of Health, 1996)³. In terms of lifetime prevalence, Andrews and Lewinsohn (1992) suggested rates of 10.1% for females and 3.8% for males (an average of 7.1%), from a sample of 1710 older adolescents. Furthermore, Andrews and Lewinsohn argued that lifetime rates of suicidal behaviour among high school students (of both genders) may be as high as 11%. Moreover, it is acknowledged that figures given for hospitalisation for non-fatal suicidal behaviour do not reflect overall rates of the behaviour, which may be much higher⁴.

Although there are many ways in which suicide might impact upon society, only the economic cost has been studied in any depth. Coggan, Fanslow, Miller and Norton (1997) estimated the total economic cost of *attempted* suicide in New Zealand in 1992 at \$11,811,449. This figure was based on \$4,569 per victim and included counselling costs, emergency treatment, hospital stay and loss of productivity. One can only

² These figures are calculated from mid-year to mid-year.

³ The definition of 'Maori' used by hospitals and health information services has changed – see below.

⁴ See page 6 for a discussion of the accuracy of these statistics.

assume that the figure has risen over the decade since, as both attempted suicide rates and related costs have risen. Coggan and colleagues suggested that this is likely to be an underestimate, as suicide attempters may not be labelled as such by hospitals. In addition, this figure appears to relate only to those who are hospitalised.

Suicidal behaviour may be presumed to impact upon society, as it has been illegal and condemned as sinful or immoral in many cultures (Lester & Yang, 1995). Suicidal behaviour may also be seen as a negative comment on the State and the competency of the mental health profession, although Maris (1981) suggested that the inherent harshness of the human condition meant that no society could be free of suicidal behaviour. The most obvious impact of suicidal behaviour is the potential for it to lead to further 'copycat' instances (Agnew, 1998; Brent, Perper, Moritz, Baugher & Allman, 1993; Hawton & Williams, 2001; Pirkis & Blood, 2001a; Pirkis & Blood, 2001b). This phenomenon is well-known, especially in regard to the suicide of celebrities. It also holds true for family members, as will be discussed in the next chapter.

Despite the prevalence of non-fatal suicidal behaviour and the associated social costs, until very recently it had received comparatively little research attention, particularly in the Aotearoa/New Zealand context. The research that has been conducted has focused almost exclusively on risk factors. Very little research has addressed intervention and cessation. The focus on prevalence and causative factors to the detriment of research into recovery appears common to all spheres of mental health research (Anthony, 1993). As McKeown, Garrison, Cuffe, Waller, Jackson and Addy (1998) pointed out, with regard to the study of causative factors, until recently, international literature on the prevention of non-fatal suicidal behaviour has tended to focus on proximal risk factors; acute situations that may be construed as crises by adolescents, such as relationship break-up and school difficulties. McKeown and colleagues found that focusing on proximal factors may result in the fundamental role of underlying environmental factors being overlooked. Blumenthal (1990) suggested that there are five overlapping spheres of vulnerability, (psychiatric disorders, personality traits, psychosocial, biology and family history), and it is the quality and interaction of these spheres that determines the risk for non-fatal suicidal behaviour.

Furthermore, *non-fatal* suicidal behaviour is assumed to be an adjunct of suicidal behaviour generally and prevention and intervention strategies are conflated, in the sense that there are not distinct strategies. This assumption is questionable (Stengel, 1971; Weiss, 1971); the prevention strategies designed for youth suicide are problematic in terms of non-fatal suicidal behaviour. As Kushner (1995) discussed, most completed suicides are by males; generalising the results of research on cases of completed suicide to non-fatal suicidal behaviour, which is usually engaged in by women, risks transferring inappropriate assumptions. As will be discussed in detail in Chapter Two, male and female suicidal behaviour is different, not only in terms of rates, but also in terms of risk factors and surrounding attitudes.

McKeown and colleagues (1998) suggested that suicidal behaviours exist on a continuum, with increased risk for completed suicide related to the increased number and severity of both proximal and distal risk factors. Given the low base rate of completed suicides and the difficulty in researching their precipitating factors, these researchers argued that concentrating on the more frequent non-fatal suicidal behaviour should prove more successful in developing accurate screening programmes. Additionally, many people who attempt suicide go on to repeat the behaviour. A recent study by Beautrais, Joyce and Mulder (2000) with over 300 participants, found that within 30 months of having made a serious suicide attempt, 7% of people had died (with the majority of these deaths from suicide) and 51.7% had made at least one further suicide attempt. By assisting suicide attempters to deal with the factors underlying their behaviour, it should be possible to reduce further attempts and deaths.

Statistics

As discussed above, Aotearoa/New Zealand has one of the highest rates of youth suicide in the world: approximately 30 male suicides per 100,000 population per year (second highest of OECD countries), and 6 female suicides per 100,000 population (fourth highest of OECD countries) (New Zealand Health Information Service, 2002). In 2000 this equated to 113 young men and 29 young women (Ministry of Health, 2001). However, non-fatal suicidal behaviour and suicidal ideation⁵ are considerably more common. In addition, while the latest figures suggested that rates

⁵ Thoughts of suicide that may or may not result in suicidal behaviour.

of completed youth suicides may be slowly declining, from 22.5 per 100,000 in 1990 to 18.1 per 100,000 in 2000 (both genders) (Ministry of Health, 2002), the trend for self-injury is less clear. From 1995 to 1998 the rate of self-injury decreased, but in 1999 it increased (Ministry of Health, 2002). This is not to suggest that completed suicide is over-researched or undeserving of the focus of attention that it currently receives. Rather, the point is that non-fatal suicidal behaviour may in fact be an even greater problem than is currently acknowledged. In 1999/2000, 1054 people aged 15 to 24 were hospitalised for non-fatal suicidal behaviour. Nearly two-thirds were females: 698 (Ministry of Health, 2002); this equated to 268.3 per 100 000.

Up until age 12, hospitalisation for non-fatal suicidal behaviour appears to be very uncommon, fewer than 10 children per 100,000 population each year. In the case of young women between ages 12 and 14 the rate leaps to approximately 350 per 100 000, and remains relatively stable until age 20, at which point a decline in hospital admissions begins. By age 30 the rate is approximately 170/100,000 and by age 45 the rate has decreased to less than 100. In contrast, the rates of hospitalisations for young men rise more slowly, peaking at approximately 230 per 100,000 at age 21, and begins to decline immediately (Ministry of Health, 1996)⁶.

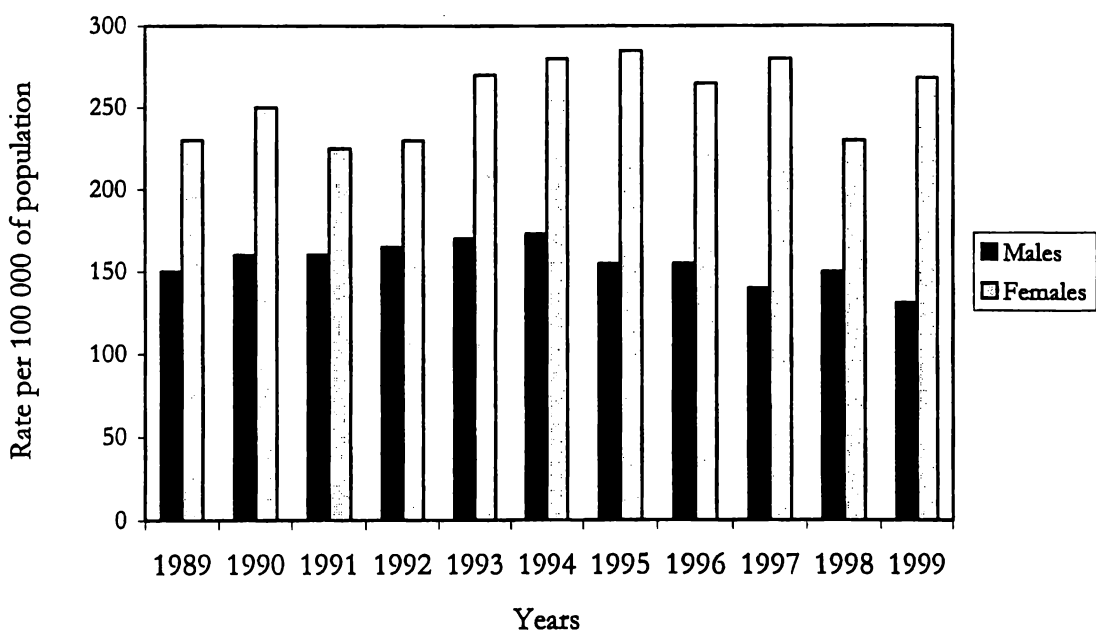
In a study of non-fatal suicidal behaviour involving young New Zealanders of both genders, Fergusson and Lynskey (1995) found that those who attempted suicide could be distinguished from those reporting suicidal ideation alone⁷. The sample consisted of 954 sixteen year olds. By the age of 16, 15% of the sample reported having either made a suicide attempt or experienced suicidal ideation. (All those who reported making an attempt also reported suicidal ideation.) Of the attempts, approximately 20% required hospitalisation. The authors noted that the prevalence of suicidal behaviour appeared to be slightly lower than usually reported. However, these participants may have been reluctant to divulge this information in an interview situation.

⁶ The latest statistics available at the time of writing indicate that although youth had the highest rate of hospitalisation between 1991 and 1998, the highest rates by age in 1999 were among the 25-34 year age group (208 per 100 000), followed by youth (202.1 per 100 000). This increase in the older group appears to be solely due to an increase in the male rate, as females aged 15-24 continue to have the highest hospitalisation rates by gender (Ministry of Health, 2001).

⁷ That is, thinking about suicide without necessarily acting on those thoughts.

Suicidal behaviour is markedly different for males and females, as will be discussed in Chapter Two. Data suggests that non-fatal suicidal behaviour has been the fifth leading cause of hospitalisation for young women (Department of Health, 1988). Males are far more likely to complete suicide, while females are far more likely to engage in suicidal behaviour in general, and non-fatal behaviour in particular. See Figure 1 for a graphic illustration of these disparities. Females appear to be more likely to make repeated suicide attempts; a recent study of young people presenting at Auckland hospital emergency departments indicated that of those who had at least one previous hospital presentation for self-harm, 78% were female (Bennett, Coggan, Hooper, Lovell & Adams, 2001).

Figure 1: Youth hospitalisation rates for self-inflicted injury, total population by sex, 1989-1999.



Adapted from: Ministry of Health (2000, 2002)

It is important to note that an unknown number of people who attempt suicide are not included in statistics because they are treated on an outpatient basis at Accident

and Emergency units, or by general practitioners, or do not receive medical treatment at all (Bennett et al., 2001). Although Meehan, Lamb, Saltzman and O'Carroll (1992) found that only 56% of American students who had attempted suicide sought medical care, statistical data in New Zealand (as with most countries) is based on hospital admissions. In other cases, the injury may be explained as an accident. On the other hand, hospitalisation figures do include people whose intent was not death and people who died while in hospital. If an individual is admitted more than once, each incident is counted as a new instance: in other words, figures represent the numbers of instances of hospitalisations, not the number of people who are hospitalised. Bennett and colleagues (2001) found that 52% of all young people who presented to Auckland Emergency Departments with suicide attempts were hospitalised; from this we can reasonably extrapolate that the rates of hospital presentation are approximately double that of hospitalisation. In addition, changing treatment methods make comparisons across years somewhat inaccurate (Brooke, 1974); for example, improved methods of treating overdoses mean that fewer people are formally admitted (Ministry of Health, 1996, 2001; Hatcher, 1997). Furthermore, the rates of both completed suicides and non-fatal self-injury may be under-reported due to the difficulty in determining intent. As a result, we presently have no way of knowing the actual rates of suicidal behaviour.

We can not generalise information gathered from hospital admissions to all young women who deliberately self-injure, as those who make attempts that require hospitalisation may differ in other ways from those whose behaviour is not medically serious. American research has found that between 4% and 9% of college students have either made a suicide attempt or had a serious suicide plan (Street & Kromrey, 1994). However, these figures cannot be generalised to New Zealand because American college students (both genders) are unlikely to display the same characteristics and behaviours as young New Zealand women.

Definitions:

'Non-fatal Suicidal Behaviour'

Defining 'non-fatal suicidal behaviour' is problematic. As Berman and Cohen-Sandler, (1982) and O'Carroll and colleagues (1998) pointed out, the lack of a

standardised nomenclature for classifying self-destructive behaviour has resulted in studies of 'suicidal adolescents' being too diverse for meaningful comparison.

The literature suggests that self-harming⁸ behaviour exists on a continuum, ranging from smoking, tattooing and body-piercing, through repetitive, aggressive but low-lethality behaviour such as superficial cutting, to completed suicide (for example, Favazza, 1996). While it appears that there are several obvious distinctions that can be made, boundaries remain difficult to delineate. In defining self-destructive behaviours, the time factor must also be taken into account, argued Brooke (1974). Tobacco smoking, for example, is known to cause serious health problems, but its effects are usually long-term, and smokers are not generally considered to be suicidal or even 'self-harmers'. Addictive drugs may have a greater lethality because of the risk of death from the so-called "uncontrolled overdose". Intended lethality is one means of distinguishing one type of behaviour from another. It is important to note that individuals who engage in low-lethality self-mutilation⁹ are at increased risk of suicidal behaviour including intentional suicide attempts and completed suicide, as well as suicidal ideation (Hickey, Hawton, Fagg & Weitzel, 2001), although self-mutilators and suicide attempters are usually treated as two different groups in the literature.

Early efforts to discuss the relationship between suicide and self-mutilation emphasised the interrelatedness of the two. In 1938 Menninger wrote about self-harm as an attempt at self-healing in which a suicidal impulse was focused on part of the body instead of the total body: "Local self-destruction is a form of partial suicide to avert total suicide" (p. 271). More recently, Ross and McKay (1978) wrote that the self-mutilator's actions seldom include an intent to die: "his [sic] behavior is actually counter-intentional to suicide rather than suicidal" (p. 15). Favazza and Conterio (1989) found that most patients state that their behaviour provided temporary relief from depression, depersonalisation, and anxiety. The 'self-mutilation as separate from suicide' view is found in more recent literature also (for example, Levenkron,

⁸ 'Self-harm' is used here to denote all deliberately harmful behaviour, including behaviour of both suicidal and non-suicidal intent.

⁹ Deliberately damaging behaviour, such as cutting, that is not of suicidal intent. This behaviour is often repeated frequently, and is discussed in more detail in Chapter Two.

1998). In short, the current predominant view in the literature is that self-mutilation is distinct from suicide, with different intentions and a different population; in practice, the distinction may be harder to make.

Gauging a person's intent to die is difficult, and it is common for an individual to change her/his mind during the process of committing suicide (Farberow, 1991; Greenwood, 1996). In addition, research suggests that many young people who attempt suicide wish to escape from their circumstances, rather than to die, but death seems to be the only available option (for example, Blau, 1996; Keinhorst, De Wilde, Diekstra & Wolters, 1995). In addition, as reviewed by Stephens (1995), a common theme in the literature is that females often engage in suicidal behaviour to manipulate others. Furthermore, individuals may be unclear about what it is they hope to achieve. As Eaton and Reynolds (1985) discussed, there has been considerable debate over the relationship between the individual's intent and the lethality of the act performed. They argued that subjective self-report by patients regarding the intended consequences of their behaviour is often unreliable, and that classifying 'suicide attempters' on the basis of lethality of their behaviour may lead to inaccurate results.

Due to the gender disparity in overall rates of suicidal behaviour, and an apparent neglect of the role of gender in suicidal behaviour in New Zealand, in this thesis I am primarily interested in young women who intentionally cause potentially lethal harm to themselves. This is 'high-lethality/low repetition' behaviour that includes 'suicide attempts', although in the literature it may be referred to as suicidal behaviour, suicide attempt, suicidal gesture, parasuicide or self-harm. This behaviour is described by O'Carroll and colleagues as:

Potentially self-injurious behavior for which there is explicit or implicit evidence either that (a) the person intended at some ... level to kill himself/herself, or (b) the person wished to use the appearance of intending to kill himself/herself in order to attain some other end (O'Carroll et al., 1998, p. 34).

This definition allows for women whose intentions are unclear to be included in the study. It excludes self-mutilation in which the intent is not suicide or the appearance of a suicide attempt. In this thesis the behaviour is termed 'non-fatal suicidal

behaviour', largely because it appears to be the most concise and accurate term of those currently in use. However, it is acknowledged that some incidents will be overlooked because it is unclear whether injury was deliberate (for example, car accidents).

Additionally, it should be noted that operational definitions are not always given in the literature. Attempts have been made to confine the material examined to that which is clearly discussing the behaviour or phenomena of interest – non-fatal suicidal behaviour. Where this is not possible, the original terminology is retained. Further, where the term 'suicidal behaviour' is used (as opposed to 'non-fatal suicidal behaviour'), the behaviour under discussion includes completed suicide.

This thesis also discusses high repetition/low lethality self-mutilative behaviour that is not suicidal in intent, as it relates to non-fatal suicidal behaviour. In the literature I have had access to, this behaviour has variously been termed self-injury, self-harm and self-mutilation. The term 'self-mutilation' is used here in preference to 'self-harm' because the latter is often taken to include relatively passive behaviours such as smoking, while the former is more frequently construed to describe active, deliberate or aggressive damaging behaviour, and also because it appears to currently be the most common term.

As discussed elsewhere, New Zealand statistics on hospitalisations for intentional self-injury do not distinguish between non-fatal suicidal behaviour, fatal suicidal behaviour (wherein the patient dies in hospital) and self-mutilation that is not suicidal. Although the terms suicidal behaviour and self-mutilation are used wherever possible in this thesis to distinguish between the two, when referring to statistics this distinction is not possible, so of necessity the term self-injury is used.

'Maori'

Shifting definitions are also a problem in relation to ethnicity. The classification of ethnicity used in health statistics was changed in 1995. As a result more people are now categorised as Maori. This has obvious implications for data analyses: comparing data obtained pre- and post-1995 without accounting for this change will lead to inaccurate results.

Statistics compiled using data gathered prior to 1995 indicate that Maori have a markedly higher rate of self-injury than non-Maori. Each year from 1981 to 1993, approximately 450 young Maori females per 100,000 population were hospitalised, 270 non-Maori females, 250 Maori males and 120 non-Maori males (Ministry of Health, 1996, 1999). However, these statistics use the biological definition, that is, in order for an individual to be classified as Maori they must have had at least 50% Maori blood. Statistics that use the new definition, which is based on individuals' ethnic identification, suggested that the hospitalisation rate for Maori females (but not males) was slightly *lower* than non-Maori for the years 1992 to 1999, with the exception of 1994, when the Maori rates were very slightly higher (Ministry of Health, 2000; Ministry of Health, 2002). The most recent statistics (1999) put the Maori female rate of hospitalisation at 224.4 per 100 000, and the non-Maori female rate at 279.6 per 100,000 (Ministry of Health, 2002).

In this thesis, participants have simply been asked to which ethnic groups they belong.

'Youth'

The World Health Organisation defines 'young people' as those aged between 10 and 24 years. However, 'youth' are more frequently categorised as those aged 15 to 24 years, and this is the case in many reported and articles on this topic (Ministry of Health, 1996). Although, according to statistics, non-fatal suicidal behaviour is relatively rare in those aged under 15, the discussions participants in this research suggested that suicidal behaviour in the under 15 age group is considerably more widespread than commonly believed. For these reasons, for the purpose of this thesis 'youth' are defined as those aged under 25.

Purpose of the Research

Due to the prevalence of suicidal behaviour among young women (especially non-fatal behaviour), and the dearth of local research with this group, the population of interest in this thesis is females who engaged in non-fatal suicidal behaviour while

aged under 25. As will be discussed in Chapter Two, much of the literature on youth suicidal behaviour focuses on risk factors, with a relative paucity of research on cessation and interventions, and is not gender-specific – particularly literature located in the New Zealand context. Yet it appears that gender is a significant issue.

Chapter One has provided statistics on the gender disparity, although, as explored elsewhere, statistics derived from the aetiology of suicidal behaviour are liable to lead to misconceptions of the problem (Berman & Cohen-Sandler, 1982). Nevertheless, it is clear that young women are hospitalised more frequently for self-injurious behaviour than any other demographic group. Additionally, due to the means chosen, self-injury that does not result in hospitalisation appears more frequent in females. Moreover, it appears that the risk factors that lead to suicidal behaviour differ according to gender, as do young people's attitudes to suicidal behaviour. This difference may influence the effectiveness of intervention and prevention strategies.

Most data about youth suicidal behaviour currently available is derived from studies with clinical samples; however, according to Jan de Wilde (2000), the majority of young people who engage in suicidal behaviour do not enter a clinical setting (in America at least). As Berman and Cohen-Sandler (1982) pointed out, we cannot assume that what we learn from clinical populations is generalisable to the wider population.

The goal of this thesis is determining the social and environmental aspects that are involved in the initiation and cessation of non-fatal suicidal behaviour in young women. It is expected that by identifying these factors, insight will be gained into potential prevention approaches. This thesis seeks to go beyond determining correlates of risk factors and to explore the lived experiences of women who have engaged in suicidal behaviour, and to represent the meanings women attribute to their experiences. It is also hoped that participants will be able to offer insights into their recovery from suicidality, discussing interventions that may or may not have helped them as well as social support (or the lack of it). This, in turn, may lead to suggestions for future intervention and prevention strategies.

Specifically, this thesis examines the social context in which young women's suicidal behaviour occurs, exploring the roles of the family, friends and the wider environment in the initiation of suicidal behaviour and its cessation, alongside an

exploration of the part played by counsellors and mental health professionals.

Questions that will be considered include:

What do young women consider to be the background features to their suicidal behaviour?

Were there immediate triggers to suicidal behaviour?

How have personal relationships influenced these factors?

What social support networks were engaged in by young women, both before and after suicidal behaviour?

What affect does suicidal behaviour have on personal relationships?

How important is the adequacy of social support networks to cessation?

How do young women who have engaged in suicidal behaviour perceive their contacts with counsellors, therapists and other service providers?

How do these service providers perceive their relationships with young women at risk of or recovering from suicidal behaviour?

How can the needs of young at-risk women best be served by these service providers?

The next chapter explores the literature on youth suicide generally, with a particular focus on the non-fatal suicidal behaviour of young women. It includes material on risk factors, precursors to suicidal behaviour, overviews of other forms of self-harm and discussions of intervention and prevention strategies.

CHAPTER TWO: INITIATION, CESSATION AND PREVENTION: A REVIEW OF THE LITERATURE

Chapter One of this thesis introduced the topic, provided statistics on suicidal behaviour and offered definitions of relevant terms. This chapter builds on the previous chapter with a continued exploration of the literature on suicidal behaviour. Through a more detailed examination of the risk factors and initiation of non-fatal suicidal behaviour, cessation, and prevention an attempt is made to provide an overview of current knowledge of non-fatal suicidal behaviour in young women. It should be noted that overall the literature on youth suicidal behaviour is vast; of necessity the following review represents an attempt to provide an overview of the most relevant material, rather than a comprehensive discussion of the literature. The chapter begins with an examination of initiation, opening with a discussion of risk factors, grouped into the spheres of biological/pathological and social factors, then moving on to an exploration of precursors to non-fatal suicidal behaviour such as other self-harming behaviours. A section on cessation and recovery follows which encompasses interventions and treatment, and repetition. The chapter concludes by reviewing the literature on prevention.

Over the last decade youth suicidal behaviour has been a topic of growing concern in New Zealand. As a result, New Zealand has an increasingly substantial body of research into youth suicide risk factors and their correlates. However, despite the consequent rapid growth in literature, as yet there are a range of topics that have received only limited attention by local scholars. In particular, as noted by Terling Watt and Sharp (2001), few studies have examined gender differences in adolescent suicide risk, and this observation is also true for New Zealand. For this reason, much of the literature discussed in this review is American or European in origin; the questionable validity and applicability of the findings to the local context must be noted. However, wherever possible, local material has been included, and is noted as such. In addition, the focus of research, both internationally and locally, has tended to be on diagnostic and risk factors, typically using quantitative measures. The relative brevity of the discussion of prevention and intervention reflects the comparative paucity of literature on these topics.

Risk Factors & Initiation

Blau (1996), reviewing American literature, identified gender, minority status, societal conditions, family dysfunction, drug/alcohol abuse and depression as general risk factors. Blau acknowledged that although more males complete suicide, more females engage in suicidal behaviour over all; therefore females are more at risk of suicidal behaviour. He argued that although long-standing problems increase an individual's vulnerability to suicidal behaviour, a crisis usually occurs immediately before a suicide attempt. These crises may be an intense conflict with a significant other, death or illness of a loved one, break-up of a relationship, pregnancy, suicide attempt by a friend or acquaintance, educational disappointment or the separation, divorce or remarriage of parents (Blau, 1996). The New Zealand Ministry of Health suggested a similar list of risk factors: psychiatric disorder; stressful life events (such as relationship break-up or unemployment); family dysfunction or instability; sexual or physical abuse; problematic behaviour; exposure to suicidal behaviour and sexual orientation identification problems (Ministry of Health, 1996).

Fergusson and Lynskey (1995) suggested that those engaging in suicidal behaviour are characterised by a greater burden of psychosocial risk factors, such as higher rates of psychiatric disorder, problems of adjustment, and exposure to family adversity. Fergusson and Lynskey suggested that suicidal ideation in the absence of other risk factors is not typically associated with an increased rate of suicidal behaviour. Perhaps their most interesting finding is that suicidal young people often come from dysfunctional family circumstances, characterised by familial conflict and instability, parental substance abuse or offending, and economic disadvantage. Smith and Beautrais (1999) suggested that, compared to the general population, young people, and particularly young women, who are in contact with welfare services are at greater risk of suicidal behaviour. This appears to fit with the pattern of characteristics presented by Fergusson and Lynskey, above.

As mentioned in Chapter One, focusing on proximal¹⁰ factors may result in the fundamental role of underlying environmental factors being overlooked. Recent research suggests that suicidal behaviour should be considered to be the result of a

¹⁰ Proximal: immediate 'triggers'.

complex interaction of factors, with the central issue being the reciprocal relationship of the individual and his or her environment (van Heeringen, Hawton & Williams, 2000). Marusic and Farmer (2001) argued that the traditional system of classification of risk factors such as biological, medical, psychological, social, cultural and economic is problematic. Most important is the overlap between categories, often occurring due to an inter-relationship. For example, unemployment may exacerbate depression, which in turn may impact on the likelihood of gaining (or keeping) employment. Marusic and Farmer went on to argue that a more promising method for identifying and classifying risk factors would be to consider them to include both biological and environmental factors, and their interactions. The difficulty of separating risk factors into categories is demonstrated in this thesis. Initially an attempt was made to order factors into five categories; however, the degree of overlap was so great as to render the classification process impossible. Despite this, I felt that some grouping was required, simply to create a logical structure to the chapter. Although classification has been restricted to two broad categories – pathological/biological and social factors - some overlap remains, both between the two main categories, and within the subsets that comprise them.

Pathology

This section outlines the pathological factors most commonly associated with female suicidal behaviour. It provides some critical discussion of the development and application of these diagnoses before discussing various psychopathologies such as depression, personality disorders, post-traumatic stress disorder, and conduct disorder. A brief discussion on the role of genetics follows.

While rates of suicidal behaviour are elevated among those with schizophrenia, this thesis is primarily concerned with suicidal behaviour in non-clinical populations. Schizophrenia is rare in the general population of young women, so is not included in this thesis. For the same reason, suicidal behaviour in the terminally ill is not discussed.

As Lewinsohn discussed in 1993, suicide attempts in adolescents are considered indicative of psychopathology. Barwick (1992) reported that between 90 and 98% of young New Zealanders who complete suicide had a diagnosable (although not

necessarily diagnosed) mental illness; Beautrais, Joyce, Mulder, Fergusson, Deavoll and Nightingale (1996) reported rates of 90%, and 20% among controls. The most commonly diagnosed categories of disorders are affective disorders, such as depression; personality disorders; substance dependence; conduct disorders; adjustment disorders and psychotic disorders, such as schizophrenia. Co-morbidity is also common (Ministry of Health, 1996).

Authors from Foucault (1967) to Szasz (1973) have suggested that mental illness is not a medical or scientific concept, but simply a judgement that devalues or explains some behaviours. Deciding when common human experiences such as sadness, nervousness or memory lapses are evidence of mental illness involves setting rather arbitrary boundaries, according to Kutchins and Kirk (1997). The criteria for diagnoses set out in the DSM¹¹ may lead to unwarranted diagnoses if the individual's social context and history are not taken into account, claim Kutchins and Kirk (1997) and Lerman (1996). Wiener and Marcus (1994) argued for a shift in perspective from the focus on the individual to sociocultural transaction patterns and contexts.

From an anthropological viewpoint there is also questioning of whether the DSM's disorders are applicable cross-culturally. Psychiatric disorders may well be 'culture-bound' (Kleinman, 1988; Kutchins & Kirk, 1997), a point exemplified by Szasz when he commented that:

... Soviet psychiatrists found that persons who cannot - or do not - control their displeasure with the political system of their own country suffer from *creeping schizophrenia*, while American psychiatrists find that persons who do not control their greed when in a casino, suffer from *pathological gambling* (1987, p.14, original emphasis, cited by Lloyd, 2001, p. 156).

Caplan (1995), Kirk and Kutchins (1992), Kutchins and Kirk (1997), Lerman (1996) and others argue that the processes underlying the development of the DSM are

¹¹ DSM is the commonly used abbreviation for the 'Diagnostic and statistical manual of mental disorders', used internationally to diagnose mental disorders. The current edition is the DSM-IV-TR (American Psychiatric Association, 2000).

fundamentally flawed, particularly in relation to depression and borderline personality disorder. In addition, human error, bias and differing realities are concerns. Lerman (1996) argued that the process of diagnosis is inextricably linked to the theoretical orientation, personality, and cultural circumstances of the assessor. She contends that mental health professionals of all viewpoints have rarely acknowledged this. Furthermore, the entire personal and cultural context in which the person being assessed lives must be considered as much as possible, and therapists must maintain an awareness that their own opinions are hypotheses, not facts. Lerman pointed out that historically both the people who wrote the DSM and the majority of those using it have been White, middle-class men; as a result the classification system is based on patriarchal, ethnocentric perceptions. As Wiener and Marcus (1994) pointed out, 'observations' are constructions seen through the lens of a particular sociocultural matrix. Good mental health has been connected to independence, self-sufficiency, and self-motivation, yet Durie (1984) argued that these qualities are the antithesis of Maori societal values, which further illustrates the need for caution in applying American psychiatric models to New Zealand society (and others) without consideration of cultural diversity.

Using the example of depression and the findings of social psychologists, Wiener and Marcus contend that fundamental attribution errors often occur when people classify non-normative or unusual conduct; observers consistently overestimate internal or dispositional factors when asked to account for another person's conduct. Clearly health professionals must make conscious efforts to avoid biases. Yet the labels within diagnostic systems have been reified, according to Lerman (1996). Despite the importance placed on the inter-relationship of a number of risk factors, including social factors (Blau 1996; Marusic & Farmer, 2001; Van Heeringen, Hawton, & Williams, 2000), much of the research continues to focus on psychopathology.

In a New Zealand study of 129 people aged under 25 who made medically serious¹² suicide attempts, Beautrais, Joyce, and Mulder (1998) found strong associations

¹² Medically serious suicide attempts were defined as requiring hospital admission for at least 24 hours and meeting other criteria such as either requiring specialised treatment (for example surgery under general anaesthetic or medical treatment beyond gastric lavage) or using methods with a high risk of fatality such as gunshot or hanging.

between a range of mental illnesses and increased risk of a medically serious suicide attempt or attempts. Rates of affective, substance use, anxiety, eating and antisocial disorders were all significantly elevated among the participants. More than half met DSM-III-R criteria for two or more disorders in the month prior to the suicide attempt, and co-morbidity was associated with particularly elevated risk levels. Females were more than males likely to have an affective disorder (79% and 61% respectively), or eating disorders (females 14%, males 2%) while males were slightly more likely to have a substance use disorder (44% of males compared to 34% of females). In total, 90% of males and 89% of females were found to fit the diagnostic criteria for a mental disorder.

It is interesting to note that the authors use the terms 'medically serious suicide attempt' and 'serious suicide attempt' interchangeably: the implication is that if an attempt is not medically serious, then it is not serious at all, and the definition of medically serious is relatively narrow. An attempt that required gastric lavage and several days in hospital would not be considered serious (either medically or otherwise) by Beautrais and colleagues, providing no other medical treatment was required. While this may be an attempt to decrease the likelihood of including people whose intention was not suicide, the approach runs the risk of reducing the generalisability of the study through excluding those who happen to have chosen less lethal methods. In addition, rates of mental disorder in the control group were surprisingly high: in total, 30% of female controls fitted at least one mental disorder diagnosis in the previous month: 12% met the criteria for diagnosis for an affective disorder in the previous month, a further 12% for a substance use disorder and 8% for an anxiety disorder. Fifty-four percent of female controls fitted the criteria for a lifetime prevalence of any disorder. Beautrais and colleagues explain this by firstly pointing out that substance abuse disorders are relatively common in young people. However, affective disorder is far more common among the female controls at 45% (lifetime prevalence), compared to 17% for substance use disorder. Secondly, the authors pointed out that high rates of disorder are not uncommon in interview-based studies of suicidal behaviour, suggesting that this method overestimates prevalence in controls. This begs the question of whether the prevalence of mental disorders is overestimated generally, and appears to provide an example of the problems with the DSM that Caplan (1995), Kutchins and Kirk (1997), and Lerman (1996) have raised.

Mental illness classifications impact the people being labelled. The act of labelling may help to determine a course of treatment. In addition, according to Lerman (1996), the label is taken to represent an absolute truth about motives and behaviour, both in how the community reacts to 'mental illness' and within the health professions. There is a tendency to treat the individual simplistically, as the personification of the label, rather than as a complex individual. Link and Phelan (2001) provided a neat example of this: a person *has* the flu, or heart disease – they are one of us, and just happen to have an illness – but a person *is* mentally ill or a schizophrenic. Schneider (in press) discussed a variety of studies that suggested that people labelled as mentally ill are discriminated against in the employment market and socially. For example, former mental patients feel they are less appreciated by their partners, perform more poorly and are perceived to be less well-adjusted, and subjects in learning experiments have been shown to punish someone described as mentally ill more harshly than others. Indeed, Schneider provided evidence for the premise that attitudes toward the mentally ill are among the most negative perceptions toward any groups, and with negative attitudes come stereotypes and stigmatism. These attitudes may also have implication for the response of health professionals to those who engage in suicidal behaviour.

Notwithstanding concerns regarding the value of psychiatric diagnosis, the fact remains that many people who engage in suicidal behaviour are regarded as mentally ill. The following pages discuss the most common diagnoses for people who engage in suicidal behaviour.

Depression

Depression has received the most attention of all the risk factors (Blau, 1996), and it is believed to be the most common mental illness associated with suicidal behaviour in New Zealand (Ministry of Health, 1996). Lonnqvist (2000) reported that more than half of clinically depressed individuals experience suicidal ideation, and this is related to the severity of depression. Although the literature discusses the biochemical processes involved in depression (Stanley, Mann & Cohen, 1986; Traskman-Bendz, Asberg & Schalling, 1986), reviewed below in the section on genetics, social factors are also acknowledged by most theorists and researchers. The inter-relationship of biological and social factors is complex. Social factors associated with suicidal behaviour include reduced support from friends, a sense of

hopelessness and conflict with parents. It appears that these factors feed on each other. For example, the depressed person may isolate herself, and friends may begin to withdraw their support, leading to increased depression. Blau (1996) identified the following themes as being significant in depression:

- exaggerated feelings of worthlessness and lowered self-esteem
- feelings of powerlessness and external locus of control
- a negative view of the world, and of the future.

It is easy to see how the themes discussed by Blau may combine in a feeling of hopelessness. Blau suggested that it is the desire to relieve these negative feelings that culminates in the suicide attempt, rather than a desire to die per se.

A sense of hopelessness has been identified as a key factor in suicidal behaviour (Beck, 1986); indeed, it has been strongly suggested that hopelessness is more powerfully correlated to suicidal behaviour than depression. Beck (1986) suggested that hopelessness constitutes a very stable schema predicated upon previous negative experiences.

Although depression is the most common disorder diagnosed in suicide attempters, being female continues to be a risk factor for suicidal behaviour even when controlling for depression. More women than men, of all nationalities and ethnicities, suffer major depression (Wade & Tavis, 1993). There are specific risk factors more common (and in some cases, unique) to women and these are discussed in a separate section on gender, below. However, a number of alternate reasons for this sex difference have been posited. Wade and Tavis (1993) have discussed research that found that more women than men seek treatment for depression, and that some women score higher at the extreme end of depression measures, thereby resulting in erroneously high rates of depression in women. Wade and Tavis also argued that men and women express depression differently. For example, men are more likely to abuse substances than women, and this may mask depression.

Personality Disorders

Borderline personality disorder (BPD) appears to be the most common personality disorder among people who harm themselves, and personality disorders are also

commonly attributed to people who engage in suicidal behaviour, often alongside affective disorders. Indeed, Linehan, Rizvi, Welch and Page (2000) have suggested that personality disorders comprise a major risk factor for suicidal behaviour, of a severity comparable to depression. Personality disorders are characterised by long-term behaviour patterns that usually affect functioning in several areas, such as personal relationships, school or employment or personal well-being (Alderman, 1997). Borderline personality disorder is indicated by chronic and intense chaos and instability. Gardner and Chowdry (1985) identified mood lability and periods of intense depression as central features of the syndrome, along with impulsivity, which may result in self-harming behaviour. There is a bi-polar tendency to fluctuate between extremes, seeing life as either wonderful and full of promise, or terrible and hopeless (Alderman, 1997). Gardner and Chowdry discussed a progression of individuals' attempts to control dysphoria that may begin with contacting a friend or therapist or taking medication but as the dysphoria progresses, feelings of emptiness and hopelessness intensify and self-destructive behaviour occurs, such as reckless driving, cutting or burning oneself and various other means of causing self-injury.

The current view of BPD often focuses on the difficulty of helping these sufferers, of whom 76% are women, according to Kirk and Kutchins (1997). They are often characterised as emotional and unpredictable in their interactions with those who try to work with them. A history of physical and sexual abuse appears particularly common in this group. Lerman (1996) argued that when abuse history is not considered there is a tendency to see these women as unlikeable, even obnoxious. This may affect clinicians' engagement in the therapeutic process. When practitioners recognise that these individuals are reacting to traumatic histories, however, they can be treated as distressed individuals attempting to cope with their experiences. A number of theorists have noted the apparent circularity of the diagnostic criteria for BPD (for example, Kirk & Kutchins, 1997; Alderman, 1997). Self-harming may be seen as an indicator of the disorder yet the disorder may then be seen as the cause of the behaviour.

Post-Traumatic Stress Disorder

Recent research, such as Mazza's study (Mazza, 2000), pointed to a relationship between post-traumatic stress disorder (PTSD) and adolescent suicidal behaviour, which cannot be explained by either depression or gender. The work of Thompson,

Kaslow, Bradshaw Lane and Kingere (2000) suggested that African American women with PTSD are significantly more likely to attempt suicide than women without PTSD, regardless of a history of childhood maltreatment, although maltreatment is associated with an increased risk of both PTSD and suicidal behaviour. Some aspects of Thompson and colleagues' study are in agreement with a study by Prigerson and Slimack (1999) who found that female subjects with elevated depression symptoms or PTSD may be at increased risk of suicidal behaviour, as are young men who are aggressive. An English study (Joseph, Mynard & Mayal, 2000) suggested that levels of PTSD may be higher than previously recognised, with moderate levels of post-traumatic stress present in approximately 20% of adolescents who have experienced relatively common negative events such as parental divorce or witnessing a physical attack. For girls, the highest levels of stress (in order of strength of the association), were found in those who had experienced a physical attack to self, a family member with a substance abuse problem, parental separation or a life threat to a family member. In boys, the highest levels of post-traumatic stress were the same as for girls except that the experience of a physical attack to oneself did not rate highly. Post-traumatic stress disorder is also linked to self-mutilation, which is discussed in more detail below.

The exact nature of the relationship between PTSD and suicidal behaviour seems unclear. Although PTSD is clearly associated with an elevated risk of suicidal behaviour, it may be that the relationship is co relational rather than causal: the trauma that led to the disorder may also lead directly to suicidal behaviour, independent of PTSD.

Conduct Disorder

Conduct disorder has also been linked to suicidal behaviour; in a study of American psychiatric outpatients aged 8 to 17, Wannan and Fombonne (1998) found a significant interaction between depression and conduct disorder and substance abuse amongst females. Substance abuse, depression and disturbed relationships with adults were found to be predictors of suicidal behaviour in both sexes. Substance abuse and family relationships are discussed in more detail below. Fergusson and Lynskey (1995) suggested a strong association between adolescent suicidal behaviour and other problem behaviours. The most significant adjustment problems among participants in their longitudinal study conducted in Christchurch were police

contact, criminal offending, low self-esteem and lack of school attendance. However King and colleagues (2001) noted that among the American adolescents in their study, more common risk behaviours such as smoking, drunkenness and physical fighting are also independently associated with an increased risk of suicidal behaviour, even after adjusting for the presence of a psychiatric disorder.

The Role of Genetics

Roy (1986) pointed out that although it is clear that suicidal behaviour runs in families, it is unclear what is being transmitted. He noted the possibility for identification with a role model of suicide as a possible solution to emotional pain. However, he also reviewed several studies that suggested that abnormal levels of central nervous system biochemicals impact upon the potential for suicidal behaviour, and suggested that a genetic predisposition for suicidal behaviour may be inherited. Stanley and colleagues (1986) suggested that neurotransmitter dysfunction underlies all types of behaviour on the deliberate self-injury continuum, with serotonin levels being particularly important. Traskman-Bendz, Asberg, & Schalling, (1986) also suggested that serotonin levels are a factor in clinical depression, borderline and antisocial personality disorders, resulting in increased suicidality. Traskman-Bendz and colleagues also discussed the possibility that this vulnerability may be heritable. Citing twin studies and research into neurotransmitter activities Marusic and Farmer (2001) argued that many of the personality traits linked to suicidal behaviour, such as neuroticism, impulsivity and aggressiveness, may be substantially genetically determined. Marusic and Farmer suggested that although more genetic research is required, both genetic and environmental risk factors must be taken into account for interventions to be effective.

While the exact extent of the influence of genes on suicidal behaviour is currently unknown, the rate of increase of suicidal behaviour in New Zealand demonstrates that the role of genetics can only be a small part of the problem. In 1985 the rate of completed suicide for young women was 5.1 per 100,000 population; in 1996 it had nearly tripled, to 14.3 per 100,000 (Ministry of Youth Affairs, Ministry of Health & Te Puni Kokiri, 1998); by 1998 the rate had risen to 19.7 (Ministry of Health, 2000) and in 2000 it had decreased dramatically to 5.8 (Ministry of Health, 2002). It is unknown how much of this variation, particularly the recent decrease, is due to changes in medical attention received.

Summary

At least 90% of people who engage in suicidal behaviour are diagnosable with at least one mental disorder; depression is the most common, although other disorders, particularly personality disorders, seem fairly common among suicidal young women. Much of the research into suicidal behaviour focuses on treating these psychopathologies, although most researchers acknowledge the role played by social factors. Medical approaches to depression and suicidal behaviour have investigated the role of neurotransmitters, such as serotonin, and there is some suggestion that a genetic predisposition may underlie abnormal levels of the chemicals. However, given that rates of female non-fatal suicidal behaviour nearly quadrupled over a 13-year period and then fell dramatically it would appear that there are several factors at work.

Social Factors

In suicidology's foundational writing, Durkheim argued that suicide occurs when individuals lose connections with society's social institutions, and that anomie (society unable to control individuals' behaviour) will also promote suicide because the normative order which opposes suicide will be ignored (Durkheim, 1952 - originally published 1897). Although 90% of people who engage in suicidal behaviour fit the classification for a recognised mental illness, the interplay of this illness with other factors should be considered. Social factors such as gender, unemployment, schooling difficulties, sexual abuse and family dysfunction have been identified as contributing to suicidal behaviour and are discussed below. The section begins with factors of broad influence, such as gender and ethnicity, and progresses to topics with a narrower impact, such as family dysfunction.

Gender Issues in Suicidal Behaviour

As reviewed by Matthews, Hughes, Johnson, Razzano and Cassidy (2002), numerous studies suggested that there are risk factors unique to women that contribute significantly to depression; as has been discussed, depression is the most common risk factor for suicidality. Risk factors for depression that may be more common to, or are exclusive to, women are often social and include women's lower socio-

economic status, gender roles, presence of dependent children, childhood abuse, sexual abuse, domestic violence, sexual harassment and rape. Research has demonstrated that, for girls, early adolescence is a time of vulnerability to stress and distress. Compared to boys, girls are more likely to be depressed, stressed, suffer from eating disorders, experience distress over their physical appearance, and attempt suicide (Debold, Brown, Weseen & Brookins, 1999).

There is a substantial body of literature on depression and gender. The gender disparity in suicidal behaviour is also well documented in terms of the differing rates and means of suicidal behaviour. Female gender is a significant risk factor for young people who engage in suicidal behaviour, with a ratio of approximately 3 instances of female suicidal behaviour to every male incident (Lewinsohn, Rohde & Seeley, 1993), despite the fact that significantly more males than females actually complete suicide. As mentioned above, it is likely that many instances of suicidal behaviour do not result in hospitalisation, and this is particularly the case for females. In New Zealand, women tend to use less aggressive, slower-acting means of self-injury (e.g. drug overdose) than males, who are far more likely to use more lethal means such as hanging and shooting (Bennett et al., 2001; Coggan, Fanslow, & Norton, 1995). As a result, women's suicidal behaviour is less likely to be fatal, both because the means are less lethal in themselves, and because there is increased time for medical intervention between the actual act and the possibility of death occurring. Nevertheless, both suicide attempts and completed suicide rates are increasing in young women, while they appear to have stabilised among young men (Ministry of Health, 2002). Yet despite the obvious gendered differences in depression, rates of suicidal behavior and methods chosen, research which attempts to explain these differences is surprisingly uncommon. This section makes use of the literature that is available to further discuss rates of suicidal behaviour among women and risk factors that have a particular impact on women.

In 1996, females accounted for 61.4% (n=1465) of all individuals hospitalised for deliberate self-injury¹³ (Wright, Langley & Allnatt, 1999), and in 1999/2000 the rate

¹³ These figures include all discharges from public hospitals with a primary diagnosis of injury, but excludes stays of less than 1 day, readmissions, and those who died in hospital.

for females had increased to 64.4% of youth hospitalisations, and 63% of all hospitalisations (Ministry of Health, 2002). Suicide accounts for 18% of all female youth deaths and there are approximately 30 hospitalisations to every death (Ministry of Health, 1997).

Low self-esteem is an important factor in depression, and (as discussed above) 90% of people who engage in self-destructive behaviour are diagnosable with an affective disorder, depression being the most common. Prior to adolescence, rates of depression in boys and girls are very similar (Nolen-Hoeksema, 1990). However, with the onset of adolescence, female depression rates begin to increase rapidly, and early-maturing girls are at greater risk of depression and eating disorders than girls who mature with at the same age and rate as their peers (Graber, Lewinsohn, Seeley & Brooks-Gunn, 1997). Moreover, Lewinsohn and colleagues (1993) found that being female continued to be a risk factor, even when controlling for depression. McGrath and colleagues (1990) argued that emerging gender role conflicts, fear of success and devaluation of the female role are contributing factors. The normal physical changes of puberty decreased female adolescents' satisfaction with their bodies, while the reverse was the case for males (Dornbusch et al., 1984). Furthermore, Lerner and Karabenick (1974) found that young women's self-esteem is closely related to satisfaction with their body. These studies were confirmed by Gilligan, Lyons, and Hammer (1989), who found that girls are harsher in their self-appraisals than boys, particularly in regard to physical appearance. Given the age of these studies, though, these factors may currently exert less influence. A cautionary note is added by Striegel-Moore and Cachelin (1999), who pointed out that there are considerable within-group differences in self-esteem. Girls who reach puberty early are particularly vulnerable to loss of self-esteem but African-American girls seem less likely to suffer a decrease in self-esteem than European-American girls. Allgood-Merten, Lewinsohn, and Hops (1990) found that in a sample of mid-upper socioeconomic status teenagers, female adolescents reported more depressive symptoms, self-consciousness, stressful events and negative body-image, than boys.

According to Langhinrichsen-Rohling and colleagues (1998) when assessed by the Life Attitudes Schedule, young American females report more symptoms of depression than males, while males engage in more impulsive and risk-taking behaviours. Suggesting a link between suicidal behaviour and conduct disorder,

Lewinsohn (1993), found that conflict with parents had greater significance amongst the females involved in their study, indicating that the frequency and intensity of these conflicts has a greater impact on adolescent females than males; Vannatta (1997) reported similar findings. Langhinrichsen-Rohling and colleagues (1998) also found that as well as the total *number* of risk factors being higher amongst young women, when number of risk factors was controlled, the *impact* of the included risk factors was also greater among females than males.

As discussed earlier, disturbed relationships with adults are predictors of suicidal behaviour in people aged under 17 (Wannan & Fombonne, 1998). Vannatta (1997) reported on a number of risk factors that adolescent Americans appear to respond to differently, depending on their gender. In addition to family relationships, academic difficulties are significant risk factors for males but not females. Terling Watt and Sharp (2001) suggested that American girls are more responsive to a lack of caring adults and other relationship issues while males are more responsive to status indicators such as welfare dependency and attending university. This is not to suggest that economic strain and status do not impact upon young women; females also react to poor social acceptance and (in contrast to Vannatta's study), downward educational mobility and poor academic achievement (Terling Watt & sharp, 2001).

Debold and colleagues (1999) argued that many of the social and biological challenges that emerge during early adolescence are much greater for girls than boys, due to their social and psychological impact. The rules of relationships are transformed by emergence into a social world dominated by heterosexual dating. Sexuality is typically experienced as a social, psychological or physical danger. Similar feelings of risk in relationships for young New Zealand women are discussed by Parker (2002). Rates of sexual abuse increase markedly between ages 8 and 14 (Ministry of Health, 1998). The realisation that their bodies are a site of temptation, conquest or danger may facilitate a sense of anxiety or powerlessness. Cognitive development brings girls into different relationships with each other and their environment at micro through to macro levels. Debold and colleagues suggested that girls develop an awareness of their socio-political context, and how their lives are shaped by the effects of poverty, homophobia, sexism, racism, classism or disabilities during early adolescence. Working class girls do not achieve as well as their middle or upper class counterparts, regardless of academic ability. Across

ethnicity and class, adolescent girls share vulnerability to sexism, risk of abuse and teen pregnancy.

It appears that gender stereotypes extend to suicidal behaviour. Reviewing a number of studies, Canetto (1997) argued that adolescent males and females have different attitudes toward suicidal behaviour, and this may influence the methods chosen and the outcome. She discussed studies that demonstrate that American adolescents consider nonfatal suicidal behaviour to be more 'feminine' than completed suicide. Males are more critical and avoidant of people perceived to be suicidal than females, especially when the suicidal individual is male. Completing suicide is viewed as more appropriate for males than females: young men who survive a suicide attempt are perceived by their peers as less masculine and potent than those who completed suicide, violating gender-role messages of decisiveness, strength, success and inexpressiveness. Conversely, nonfatal suicidal behaviour is frequently interpreted by others as a cry for help, despite the fact that few suicidal individuals explain their motivations in this way. This type of dependency-related behaviour is portrayed as appropriate for adolescent females. Completed female suicide is perceived as more wrong, more foolish and weaker than male suicide. Similar findings were reported by VanWinkle, Calhoun, Cann, and Tedeschi (1998): in a study of White American undergraduates, females viewed suicide attempters as more justified in their attempts than males. This finding may be explained by the fact that women engage in more suicidal ideation and suicidal behaviour than men, and therefore may have more empathy for an attempter.

Although the influence of various types of music has been the subject of much debate, relatively little research has been conducted. Heavy metal rock music has probably received the most public attention in this regard as, in addition to songs that explicitly discussed suicide, expressions of personal and societal chaos and hopelessness frequently pervade the lyrics of this music type (Stack, 1998).

Reviewing the literature on heavy metal music and suicidality, Scheel and Westfield (1999) suggested that fans may have higher rates of depression, lower self-esteem, difficult family relationships and more school-related difficulties, all of which are risk factors for suicidal behaviour, as well as other associated factors such as substance abuse. In their own study, Scheel and Westfield found that heavy metal fans had

more thoughts of suicide (especially females) and less strong reasons for living (especially males). Burge, Goldblat and Lester (2002) suggested that music preferences contribute significantly to the prediction of suicidal ideation in males but not females. A study of the relationship between heavy metal music and suicidality by Lacourse, Claes, and Villeneuve (2001) also included a variety of other risk factors. Using a sample of 275 secondary school students, Lacourse, Claes and Villeneuve found that reactions to a number of predictors varied according to gender. Although powerlessness and drug use were most significantly and directly related to suicidal risk over all, drug use was more strongly associated with suicidal risk for girls, concurring with the findings of Wannan and Fombonne (1998). Father negligence was also significantly associated with suicide risk only for girls, and girls who listened to heavy metal music reported more feelings of alienation, anomie and suicide risk than both their same-sex peers and boys who listen to heavy metal. Lacourse, Claes and Villeneuve's research further suggested that girls who have poor family relationships and feelings of anomie and alienation try to release their negative emotions by listening to music, although this is not the case for boys; girls who listen to music for relief of negative emotions appear to be more troubled than boys who listen for the same reasons. Since listening to this type of music appears to reduce the risk for suicidal behaviour in girls, Lacourse and colleagues postulated that it allows girls to express uncomfortable emotions, thereby providing an effective coping mechanism, while the same could not be said for boys. They argued that boys may use "more drastic externalising behaviors" (p.329).

While most theories of gender and suicidal behaviour emphasise social aspects, Parry and Haynes (2000) suggested that reproductive hormones can have both direct and indirect effects on mood, and hence, potentially, on suicidal behaviour. These include affects on the neurotransmitter and neuroendocrine systems, as well as the response to anti-depressant medications. Graber and colleagues (1997) found that the early onset of puberty is linked to depression and suicidality in girls, while the reverse is the case for boys. Although they explained this in social terms, for example suggesting that early maturation may increase cultural pressures for thinness, it may be that biochemical processes also play a role.

Although the gender disparity in rates of depression is well-researched and well-documented, until fairly recently few studies have examined the correlates of gender

in adolescent suicidal behaviour (Canetto, 1995; Lewinsohn et al., 1993). Gender-differentiated information on means of suicide is readily available, but there is relatively little material available that discusses gender differences in risk factors or the effectiveness of interventions. It appears to be assumed that more young men complete suicide simply because they choose more lethal means (Beautrais, 2002). Although rarely stated, the apparent corollary is that young women attempt suicide several times, resulting in higher rates of suicidal behaviour in females than males, therefore skewing the statistics: it is not that more young women are suicidal, just that the same young women are counted several times. However, the information provided by statistics are inadequate. There is very little research, either locally or internationally, that actually examines why young women are markedly over-represented in the statistics on suicide attempts. In short, with some notable exceptions such as the work of Canetto (1995; 1997), Canetto and Lester (1995), Canetto and Sakinofsky (1998), Langhinrichsen-Rohling and colleagues (1998), Terling Watt and Sharp (2001), Vannatta (1997) and Wannan and Fombonne (1998) the natural assumption from a casual reading of the literature on suicidal behaviour could be that young men and young women engage in suicidal behaviour for similar reasons. Therefore it follows that interventions need not be gender-targeted: more men complete suicide, and more women attempt it, simply because women are not as efficient at killing themselves. However, a wider reading of the literature incorporating studies of gender and depression challenges this view: overall, it seems that young women face more risk factors than young men, and some of the risk factors they share have a greater impact on young women. Males and females differ in the ways they respond to distress (Langhinrichsen-Rohling et al., 1998), and may also differ in the ways they respond to intervention and prevention strategies. This topic is worthy of further research.

Ethnicity Issues

Some of the literature discussed above (for example, McGrath et al., 1990) examines deliberate self-injury and suicidal behaviour from a feminist perspective, arguing that women may be directly or indirectly affected by discrimination, powerlessness and devaluation as a result of gender role stereotyping, possibly resulting in depression and a sense of hopelessness. One may argue that members of non-dominant ethnic groups are also likely to be subject to these factors, particularly in the case of

colonised countries. Discrimination, powerlessness and devaluation may well lead to other risk factors such as poor health, lower education levels, unemployment and other sources of stress, and less access to suitable health resources.

McGrath and colleagues (1990) discussed the bleak mental health status of an indigenous group, Native Americans. Suicide is twice as high among Native Americans than among the general American population, and it is likely that the non-fatal suicidal behaviour rate is similarly disproportionate. McGrath and colleagues suggested that poverty and lack of education are among the contributing factors. In addition, a statistically significant proportion of Native American women who come to the attention of mental health services have experienced sexual assault, and are at risk of self-medicating with alcohol and other drugs as a response to these stressors. These researchers suggested that African American/Black women are faced with a number of mental health issues as a result of their historical, cultural and structural position within American society. These issues are reflected in higher rates of ill-health and substance abuse, but Black American deliberate self-injury rates are lower than white American rates (Neeleman, Jones, Van Os & Murray, 1996). However, as McKeown and colleagues (1998) pointed out, few studies of self-destructive behaviour include substantial numbers of ethnic minority participants. In addition, the lower rates among African American women could be due to a reporting anomaly; for example, African American women may be less likely to seek assistance at hospitals.

An exception to this is a British study by Goddard, Subotsky, and Fombonne (1996) which compared a similar number of Black and White adolescents. They found that the rate of referrals to a psychiatric service for deliberate self-injury reflected the community composition, and the backgrounds, symptoms and circumstances of the two groups were similar, except that the Black group reported more social stress. In a study of Aborigines in South Australia, Clayer and Czechowicz (1991) found that there was a disproportionately high rate of suicidal behaviour among that population, whose position they considered to be similar to that of Native Americans. Both have experienced extensive social disintegration as a result of colonisation.

As discussed above, women who engage in non-fatal deliberate self-injury appear likely to be survivors of trauma. Furthermore, there appear to be links with poverty,

physical well-being (or the lack thereof), and depression. In these regards, statistics on the health and well-being of young Maori make grim reading. Young Maori are more likely than young Pakeha to live in circumstances generally associated with an increased risk to well-being. In 2000, over a third of Maori left school with no formal educational qualifications, compared to 16% of the general population. The 2000 census results also showed that just over one-third of Maori aged 15-19 who were available for work were unemployed, compared to 17% of the general population for that age group (Statistics New Zealand, n.d.). As at 1995, Maori children were nearly four times more likely to be hospitalised for abuse than non-Maori¹⁴. In 1994, 51% of Women's Refuge clients were Maori, although Maori comprised approximately 12% of the total population of Aotearoa/New Zealand at that time (Ministry of Health, 1998). From these statistics it would appear that young Maori would be at greater risk of suicidal behaviour.

Although it is clear that there has been an ethnic disparity in the rates of deliberate self-injury, many writers on the topic appear to 'gloss over' this fact. For example, a report by Coggan and colleagues (1995) drew largely on American material for their discussion of prevention and intervention strategies, despite acknowledging the ethnic disparity. While the reliance on American literature and experiences is no doubt necessary due to the paucity of local literature on the topic, Coggan and colleagues do not discuss the generalisability of American research to Aotearoa/New Zealand (other than questioning the relevance of further restricting access to guns). There is no discussion whatsoever of the application of Treaty of Waitangi articles or principles. In fact there is little mention of the ethnic disparity in deliberate self-injury rates. The word 'Maori' appears only once in the ten-page discussion of prevention and intervention, in an acknowledgement that suicides in custody make a substantial contribution to the Maori suicide rate, therefore "investigation of culturally appropriate interventions may be beneficial" (p. 104). The omission of discussion of ethnic differences in deliberate self-injury rates is common in the local literature, for example Fergusson and Lynskey (1995) and Greenwood (1996). The Fergusson and Lynskey study was based in Christchurch. Although there were fewer Maori living in the Christchurch area than the national average, Fergusson (2002)

¹⁴ However, some of this difference may be due to the biases of hospital staff, who have been found less likely to confirm cases of abuse in non-Maori children (Ministry of Health, 1998).

gave the ethnic breakdown of the total cohort (based on self-report) as 85.4% European/Pakeha; 11.3% Maori; 2.8% Pacific Island and 0.5% Asian. Given the high proportion of Maori national deliberate self-injury hospitalisations at the time of the study, it seems reasonable to expect some mention of ethnicity in their report. Admittedly Greenwood has a small sample in her qualitative study but she does not mention the ethnicity of her participants. However, there have been some attempts to address the ethnicity issue by other researchers. These are discussed next.

Barwick (1992) asserted that it is feasible to generalise from international studies on acculturation through colonisation to the Maori situation. However, this hypothesis has yet to be tested. Langford, Ritchie, and Ritchie (1998) argued that the alarming increase in non-fatal suicidal behaviour is a result of economic and social changes which have increased stress on families and youth, which in turn is linked to risk factors such as depression, substance abuse, aggressive behaviour, family violence and schooling difficulties. In addition to these risk factors, they argued, Maori are subject to the additional issues of deculturation and colonisation. In addition, the University of Auckland's Injury Prevention Research Unit is taking steps to address this deficiency, with projects on Maori and Pacific Island youth suicidal behaviour currently being conducted by Nicole Coupe and Jemaima Tiatia respectively.

Keri Lawson-Te Aho, in her report *Kia Piki Te Ora o te Youth*, the New Zealand Youth Suicide Prevention Strategy (1998), argued that there is a clear relationship between culture and behaviour, and that this relationship needs to be recognised in the design of Maori youth suicide prevention strategies. However, a review of the New Zealand-based suicidal behaviour prevention and intervention literature revealed a wide variation in the way the issue is addressed. At one end of the spectrum is the report by Coggan and Patterson (1998), mentioned above. At the other end of the spectrum is Lawson-Te Aho's work (1998), which is clearly located within a Treaty of Waitangi framework and seeks to formulate specific preventions and interventions for Maori. It was commissioned by the Ministry of Youth Affairs and Te Puni Kokiri, and is explicit in its aim to provide the basis for a strategy for the prevention of Maori youth suicide. The strategies contained in the report comprise both government initiatives and community initiatives. Adherence to the principles of partnership, protection and participation is explicit throughout the document, particularly in "Goal Four: Mainstream Responsiveness" (p. 15), which

discussed the need for mainstream services to respond appropriately and effectively to the needs of Maori youth through the establishment of partnerships with Maori. Lawson-Te Aho argued that young Maori will have a lifetime of dealing with mainstream institutions, so it is important that these institutions contain people, processes and performance standards that are capable of meeting the requirements of youth and the whanau.

Similarly, the New Zealand literature pays little, if any, attention to the possibility that the long-term effects of colonisation are a factor in Maori suicidal behaviour, apart from Barwick (1992), Langford and colleagues (1998) and Lawson-Te Aho (1998). Assisting in the development of self-esteem and self-efficacy and establishing a context of support and collective responsibility among Maori are some of the avenues through which Aotearoa/New Zealand can begin to reduce the Maori suicide rate. However, in order to do this wider socio-political issues may need to be addressed.

Media Influences

Clearly, a wide range of factors may contribute to suicidal behaviour. In addition to personality and psychological factors, exposure to suicidal behaviour in others is a relevant factor. This exposure may occur as a result of the behaviour of family, friends or neighbours. It may also occur through the media.

A large body of evidence suggests a link between media representations of suicide and subsequent increases in suicidal behaviour (New Zealand Youth Suicide Prevention Strategy, 1999). While until recently the research has been somewhat inconclusive, young people who are struggling with personal problems appear particularly vulnerable. 'Copycat suicide' or suicide contagion has been linked to books, television programmes, movies, magazine and newspaper articles which appear to normalise suicide (New Zealand Youth Suicide Prevention Strategy, 1999). It is argued that young people model their behaviour on what is presented to them as normal ways of solving problems. If suicide is widely reported and discussed, it may be seen as normal. Reporting of celebrity suicides may be particularly dangerous. In New Zealand, the media is restricted in the reporting of suicides under the Coroner's Act (Ministry of Justice, 1988), and guidelines for the reporting of suicide have been

formulated by the New Zealand Youth Suicide Prevention Strategy (1999), an initiative of the Ministry of Health. However, the Act is currently under review, and the Press Council is calling for restrictions to be eased (New Zealand Press Association, 2002).

Reviews of the literature on media influences on suicidal behaviour by Pirkis and Blood (2001a, 2001b) and Hawton and Williams (2001) found that both non-fictional reporting and fictional portrayal of suicidal behavior are causally linked with increases in suicidal behaviour, particularly in young people. However, Hawton and Williams (2001) stress the need to remain cognisant of other factors of greater significance that lead to suicidal behaviour, while noting the need for further research into areas such as long term influences of the media, the role of the internet, the effect of modifying media portrayal and reporting of suicide and the preventive potential of the media.

Family Environment

The relationship between adverse family environment and suicidal behaviour is a common theme in the literature (Brent, Bridge, Johnson & Connolly, 1996; Ministry of Health, 1998; Sedney & Brooks, 1984) and is mentioned many times in this review. Negative family environments can take many forms, from parental discord and separation to neglect, physical and sexual violence, to poverty and associated stressors; many of these factors are inter-related. The impact of the environment varies according to the influence of a wide range of variables as discussed throughout this review, although King and colleagues' (2001) findings suggested that poor family environment (and risk-taking) is independently associated with an increased risk of suicidality, even after adjusting for socio-demographic variables and psychiatric disorder. Hollis (1996) argued that there is a risk of spurious associations because of the effect of confounding variables: disturbed family relationships may be associated with suicidality indirectly through an association with other factors such as conduct disorder or depression. Hollis' findings suggested that adolescent suicidal behaviour is independently associated with both depression and disturbed family relationships. Aspects of family relationships found to contribute significantly to risk of suicidal behaviour were family discord, lack of warmth and disturbed mother-child relationships. Hollis suggested that poor relationships within the family may result in

a limitation of opportunities for learning problem-solving and coping skills as well as a lack of social support.

Adolescent depression, impulsivity and suicidality have been linked to adoption, although the association between adoption and adolescent suicidal behaviour and the mechanisms involved are not well-researched (Slap, Goodman & Huang, 2001). Slap and colleagues conducted research into this topic with 6500 Americans aged 12 to 18 as part of a nationally representative longitudinal study. They found that 7.6% of adopted participants had attempted suicide within the past year, compared with 3% of non-adopted participants. Adopted adolescents were also likely to have received counselling, at more than double the rate of their peers. However, Slap and colleagues report that family connectedness decreases the risk of suicidality regardless of adoptive status; the key factor is the quality of the parent-adolescent relationship. The conclusion appears to be (although not explicitly stated) that in this study, adopted adolescents had lower rates of family connectedness, and therefore higher rates of suicidal behaviour than their non-adopted counterparts.

Exposure to Suicide in Family or Social Networks

As discussed in the section on genetics as a risk factor, studies demonstrate an increased rate of suicidal behaviour among the relatives of suicide victims (Roy, 1986). Some research suggested the likelihood of heritability, especially in regards to neurochemicals (for example, Traskman-Bendz, 1986; Marusic & Farmer, 2001). In a study of 58 adolescent suicide victims (both genders, although largely male) and 55 community controls, Brent, Bridge, Johnson and Connolly (1996) found that the rate of suicide attempts was increased among first degree relatives of suicide victims, even after adjusting for DSM Axis I and II disorders (for example, affective disorders, substance abuse, conduct or anxiety disorders; personality disorders). Brent and colleagues acknowledged that familial transmission of suicidal behaviour could involve non-genetic sources such as exposure to violence, separation or loss and other environmental stressors. Family members of suicide victims demonstrated higher levels of aggression as well as suicidal behaviour, providing further evidence of a suggested link between the two. However, increased familial risk of suicidal behaviour was present even after controlling for measures of aggression, which suggested independent transmission. Brent and colleagues concluded that familial

transmission of suicidal behaviour occurs by a method distinct from the transmission of psychiatric conditions.

The suicide of others may implicitly teach individuals that suicide is a possible solution to life's difficulties, especially if the suicide was of someone highly valued or respected. It may also cause individuals to examine the meaning of their own lives, perhaps leading to feelings of discontent, despair or hopelessness (Agnew, 1998). Hazell and Lewin (1993) estimated that 20% of American adolescents know of suicidal behaviour in a friend; given New Zealand's high rate of suicidal behaviour it is likely that suicidality would be even more common in the social networks of New Zealand youth, although numbers are unknown. Support for the hypothesis that exposure to suicide can increase suicide risk includes anecdotal reports of cluster suicides and attempts, statistical evidence and studies of rates following media publicity of suicides (Brent, Perper, Moritz, Allman et al., 1993). Brent and colleagues discussed findings of a 2.3-fold increase in the suicide attempt rate and a 7 to 10% increase in the completed suicide rate in a high school following media publicity about suicide. Hazell and Lewin (1993) reported some similar findings from their study of Australian high school students. Students who had been friends with both a suicide attempter and a completer had significantly higher scores on both previous suicidal ideation and behaviour, and current ideation and behaviour than other groups. A group of participants who were friends with a suicide attempter also demonstrated higher levels of suicidal ideation and behaviour than the control group, but friends of people who completed suicide did not appear to have high levels of suicidal ideation or behaviour. Hazell and Lewin suggested that friendship with a suicide attempter is an indicator of vulnerability to emotional problems. They concluded that friends of those who engage in suicidal behaviour may also have pre-existing vulnerabilities, and that attempted suicide of a friend may be at least as strong a trigger for suicide contagion as completed suicide.

Interestingly, a recent American study by Terling Watt and Sharp (2001) found that having close friends is positively associated with suicide attempts in adolescent females, but not males. Terling Watt and Sharp suggested that female friendship networks are more likely to provide a conduit for the expression of emotional distress, thereby heightening perceptions of emotional difficulties. Information about friends' suicidal thoughts and behaviour may be offered, resulting in suicidality

being accepted. If a young woman reveals suicidal thoughts or makes a suicide attempt, her friends may respond with concern and increased support, thereby 'rewarding' the behaviour. These propositions appear to fit well with Canetto's (1997) analysis (discussed in the section on gender), which suggested that female suicidal behaviour may be construed as an acceptable help-seeking mechanism.

*Sexual Orientation*¹⁵

As Remafedi (1999) discussed, researchers have been reporting elevated rates of suicidality among gay, lesbian and bisexual people for 25 years. However, a meeting of the American Association of Suicidology convened in 1994 concluded that there is no population-based evidence that sexual orientation and suicidality are linked. While Ramafedi suggested that this conclusion was both premature and over-stated, methodological issues with many studies are acknowledged, particularly a lack of examination of ethnic and sex differences. Bagley and Tremblay (2000) suggested that rates of serious suicide attempt are at least four times higher in gay, lesbian and bisexual adolescents compared to heterosexual youth. A meta-analysis of research into the relationship between sexual orientation and suicide risk (McDaniel, Purcell & D'Augelli, 2001), suggested an elevated risk of suicide attempts amongst gay, lesbian and bisexual people, especially youth. Although most studies cited by McDaniel and colleagues either do not appear to differentiate between males and females, or focus on gay or bisexual men, they suggested that lesbian women are up to twice as likely as heterosexual women to attempt suicide. However, a New Zealand study by Fergusson, Horwood and Beautrais (1999) found strongly elevated levels of suicidality in young gay, lesbian and bisexual people, with similar results regardless of gender. Fergusson and colleagues do acknowledge a possibility of under-reporting of non-heterosexual orientation – only 2.8% of their sample identified as gay, lesbian or bisexual – but suggested that this low rate may be due to their relatively stringent definitions of homo- or bisexuality.

¹⁵ While it may be argued that sexual orientation is primarily biological, this discussion is placed here because the aspects of non-heterosexual orientation which engender suicidality are thought to be social.

As a result of a study of a racially diverse sample of 862 urban American women, 550 of whom identified as lesbian and another 33 as bisexual (the remainder acting as controls) Matthews and colleagues (2002) reported that non-heterosexual orientation represents an important but poorly understood risk factor for depression and especially for suicidal behaviour among women. D'Augelli, Hershberger, and Pilkington (2001) reported that 36% of participants in a study involving 155 young lesbian or bisexual women had tried to kill themselves, with 2.92 suicide attempts being made on average. Twelve percent of attempters felt that their single or first attempt was highly related to their lesbian or bisexual status and 35% felt that it was somewhat related. The remaining 53% reported that their attempt(s) were unrelated to their sexual orientation. D'Augelli and colleagues concluded that when considered alongside the results of other studies, gay and bisexual males are at greater risk of suicidal behaviour than their female counterparts. Sexual orientation was predictive of suicide attempt in males but not females in a study by Garofalo, Wolf, Wissow, Woods, and Goodman (1999). They suggested that although there was an increased suicide risk among lesbian and bisexual females, it is due to confounding and mediating factors such as gender, age at self-identification as lesbian/bisexual and engagement in risk behaviours. Garofalo and colleagues found that females typically 'come out' at a later age than males, and suggested that a delayed 'coming out' process may decrease the stress associated with disclosure. Muir (2001) argued that identifying as lesbian or bisexual often means identifying with a stereotype girls are taught to despise. This finding concurs with that of McGregor, Carver, Antoni, Weiss, Yount, and Ironson (2001): societal attitudes toward homosexuality are usually internalised before individuals recognise their own sexual orientation, therefore individuals experience toward themselves the attitudes they have internalised, resulting in internalised homophobia.

Lesbian and bisexual women may be alienated, discriminated against and marginalized. As a result, disclosure may be delayed until suitable supportive confidants are found, or until continued non-disclosure creates problems, such as discomfort with deception (Muir, 2001). Disclosure was also considered to be a key element in increased rates of suicide attempt, in research by Hershberger, Pilkington, and D'Augelli (1997). Hershberger and colleagues found that in comparison to young men and women who had not made suicide attempts, attempters had

disclosed their sexual orientation more completely, had lost more friends as a result of disclosure, and had experienced more victimisation due to their sexual orientation.

In short, although results remain somewhat inconclusive, the weight of the research suggests that lesbian, bisexual and gay youth are at increased risk of suicidal behaviour, due to concerns about or the actual repercussions of discrimination and victimisation following disclosure of sexual orientation, but that females appear less at risk than males because of relatively harsher societal attitudes to gay men.

Social Support

Lack of social support is strongly associated with suicidal behaviour (Malkin, 1995), and good social support is linked to recovery from mental health problems, according to Lapsley, Nikora and Black's (2002) New Zealand study. Bettridge and Favreau (1995) argued that what has commonly been perceived as a 'cry for help' is in fact a 'cry for connection'. In a recent study of 100 young New Zealanders with suicidal tendencies, Smith (2001) found that those from environments where they could talk and be listened to were considerably less likely to engage in suicidal behaviour than those receiving little social support. Similarly, Magne-Ingvar (1999) reported that most hospitalised suicide attempters rated their social networks as weak at the time of their attempt. More generally, Scholte, van Lieshout, and van Aken (2001) argued that one of the most important predictors of adolescent adjustment is perceived social support, and this is related to both psychological well-being and emotional problems such as suicidal ideation. However, the reality of this perception has been questioned, as has the causal relationship (Lewinsohn et al., 1993). Lewis Harris and Davis Molock (2000) also reported on the importance of family support to young people, along with family cohesion. As a result of research with African American college students, they suggested that high levels of family cohesion and family support are associated with lower levels of depression and suicidal ideation and strong family support is also linked to fewer experiences of depression and suicidal ideation.

Stressful Life Events

A number of stressful life events may contribute to putting young people at risk of suicide. King and colleagues (2001) reported that, compared to participants with suicidal ideation only, suicide attempters are more likely to have experienced stressful life events. The more commonly cited events include precipitating events such as school failure, relationship break-up, bereavement and unemployment (Langford, 2002; SPINZ, n.d.-b; Vajda & Steinbeck, 2000), as well as distal events such as a history of sexual abuse, which will be discussed below.

Beautrais (1997) reported from a New Zealand study of young people of both genders who made medically serious suicide attempts that the most commonly reported precipitating factors were relationship break-up (24% of the sample), or interpersonal problems such as family arguments. Financial problems accounted for 8.5%, problems with the law for 7% and school problems for 6%. Although schooling difficulties are often assumed to consist of academic failure, Gust-Brey (1999) reported on a number of studies that suggested that gifted students are more at risk of suicidal behaviour than their average peers.

Suicidal ideation has been linked to a lack of academic orientation and suicide attempts have been related to poor school performance and long absences from school (Adams Thompson, Eggert, Randell & Pike, 2001). Compared with their peers, young people who are experiencing schooling difficulties such as these are at increased risk of co-occurring risk factors such as depression and drug involvement which serve to intensify their risk of suicidal behaviour, according to Adams Thompson and colleagues.

Socio-economic disadvantage is frequently identified in the literature as a risk factor (for example SPINZ, 2000). It is often discussed as a link to a more stressful lifestyle, less access to resources including health care, fewer opportunities for educational achievement (in young people), poor housing facilities and lower self-esteem.

Unemployment has been linked to suicidal behaviour, especially in older youth (Langford, 2002; SPINZ, 2000; Vajda & Steinbeck, 2000). Reporting on the results of a study of British adults, Platt and Hawton (2000) stated that there was an

increased risk of suicide and suicide attempt among the unemployed, and that the risks were inversely related to social class: the lower the class, the higher the rate of suicidal behaviour, although health professionals exhibit the greatest proportional mortality rates. In contrast are results from the Canterbury Suicide Project (Beautrais, 1997), which suggested that although the unemployed have four times higher rates of suicide attempts, the relationship is not causal. Unemployment is associated with other disadvantages that are linked to suicide risk, such as a lack of educational qualifications, childhood sexual abuse and poor parental care. Beautrais went on to argue that although the loss of employment may be a precipitating factor in some cases, the role it plays is insignificant and is likely to be played out against a background of social deprivation and personal disadvantage.

Sexual Abuse

Adults who have been victims of sexual abuse as children or adolescents report significantly greater symptoms indicative of depression, anxiety and self-abusive behaviour. Women whose abusive experiences occurred within the family are at greater risk of disturbance than other women (Sedney & Brooks, 1984). Wagner and Linehan (1994) provided confirmation of some of these findings, reporting that not only are women who have been sexually abused more likely to engage in deliberate self-injury, their behaviour is also more likely to be lethal than that of women who did not report abuse. However, New Zealanders Romans, Martin, Anderson, Herbison and Mullen (1995) argued that until recently most studies have involved atypical samples such as social agency clients and clinical inpatients, and criticisms of the link between childhood sexual abuse and later suicidality have been based on these methodological issues: for example, clinical inpatients may not be representative of the wider population of survivors of sexual abuse.

Although exact figures cannot be obtained and various definitions¹⁶ are used in the research, sexual abuse in girls and young women is not uncommon, and it is generally accepted that females are far more likely to be victims of sexual abuse than males.

¹⁶ One of the most common definitions is 'any unwanted or negative sexual experience in childhood and/or early adolescence'. Sexual abuse is defined by the Child, and Young Persons' Service as "Any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not." (Goodyear-Smith, 1993).

Indeed, the vast majority of studies on sexual abuse are conducted using only female participants.

Saunders, Villeponteaux, Lipovsky, Kilpatrick and Veronen (1992) reported that 10% of the women in their study in South Carolina had been raped during childhood, a further 15.6% had been molested and another 12% had been the victims of non-contact sexual assault (such as indecent exposure). In this study, victims were significantly more likely than non-victims to meet diagnostic criteria for agoraphobia, panic disorder, obsessive-compulsive disorder, major depression, social phobia and PTSD. Rodriguez-Srednicki (2001) reported increased rates of drug use, alcohol abuse, disordered eating, risky sex, dissociation, self-mutilation and suicidality in a sample of 175 female college students who were survivors of childhood sexual abuse, as compared to 266 female college students with no reported history of abuse. Elevated rates of depression, anxiety, low self-esteem, drug or alcohol abuse, suicide attempts and psychiatric admission were found in McCauley and colleagues' 1997 study of childhood physical and sexual abuse in American women. Similar findings are reported by Polusny and Follette (1995), Silverman, Reinherz and Giacona (1996) and Stepakoff (1998). On the other hand, the Otago Women's Health Study found that only one in five women who reported sexual abuse as a child developed a psychiatric disorder (Ministry of Health, 1998). Reviewing a number of studies, including New Zealand-based longitudinal research, Goodyear-Smith (1993) argued that the other forms of abuse and family dysfunction which tend to occur alongside sexual abuse may in fact play at least as great a part in later depression and psychological problems. Boudewyn and Liem (1995) suggested that the longer the duration and the more frequent and severe the sexual abuse, the more depression and self-destructiveness is likely. Sexual abuse has also been linked to a number of negative psychological outcomes in addition to diagnosable disorders. Effects include trouble sleeping, nervousness, thoughts of hurting oneself and learning difficulties.

Local studies suggested rates of childhood sexual abuse among females of between 17% and 38% (Ministry of Health, 1998). When studied at age 18, 17% of females in the Christchurch Health and Development Study (Fergusson, Lynskey & Horwood, 1996) reported experiencing sexual abuse before age 16. However, it has been suggested that survivors in this age group are inclined not to report the abuse they

have suffered (Ministry of Health, 1998). A study of 3000 Otago women aged 18 to 65 (Anderson, Martin & Mullen, 1993) reported 32% being sexually abused before age 16. Using a somewhat narrower definition¹⁷ of sexual abuse than some, Muir (1993) found prevalence rates of 38% among women and 10% among men in her sample of Waikato university students. The majority of participants reported feeling scared, humiliated, guilty and powerless at the time of the abuse. Fergusson and colleagues (1996) reported increased rates of major depression, anxiety, conduct disorder, substance abuse and suicidal behaviour as a result of sexual abuse. In a large random community study conducted in Otago, Romans, Martin, and Mullen (1997) found that 26% of the participants reported sexual abuse before age 12, and 32% were sexually abused by the age of 16, equating to 252 participants. Twenty-three (4.8%) of those interviewed reported a history of deliberate self-harm¹⁸, and 22 of these 23 reported childhood sexual abuse. The one woman who self-harmed without a history of childhood sexual abuse reported sexual and physical assault as an adult. It should be noted that the vast majority of women who were sexually abused did not report self-harm. By far the most common form of self-harm in Romans and colleagues' study was overdose. A clear 'dose effect' was found: the more frequent and intrusive the childhood sexual abuse, the stronger the association with self-harm. This was also found in a New Zealand study by Mullen, Martin and Anderson (1996). Sexually abused participants who had self-harmed were more likely than other survivors of sexual abuse to report depression, anxiety disorders, eating disorders and to drink alcohol in excess of the recommended guidelines. They were also more likely to have experienced psychosocial disadvantage in their families of origin, such as low care/ high control relationships with their parents, parental discord, paternal depression or alcohol abuse and physical abuse. Romans and colleagues' study clearly demonstrates that although not all women who have been sexually abused go on to harm themselves, the majority of women who harm themselves have been sexually abused.

¹⁷ "[W]hen a person under the age of eighteen years has sexual contact with a person at least five years older; the sexual contact is abusive when it is unwanted or coercive" (p. 2).

¹⁸ Romans and colleagues use the term 'deliberate self-harm', but given that the majority took overdoses, the behaviour seems closest to suicidal behaviour.

Vajda and Steinbeck (2000) found that childhood sexual abuse is a stronger predictor of repeated suicidal behavior than individual characteristics and other stressors. Both drug and alcohol abuse were independently linked to elevated risk of repetition. Psychotic conditions and chronic medical conditions were also associated with repeated suicidal behaviour.

Disclosure of abuse appears to be difficult for many survivors of sexual abuse, particularly disclosure to police or others outside their circle of significant others. This may have implications for the efficacy of counselling and therapy. International studies reviewed by Muir (2001) suggested that approximately 20 – 30% of survivors of childhood sexual abuse do not disclose until adulthood, and in over half the cases where disclosure occurred during childhood nothing was done about the abuse. Muir (1993) reported that although 75% of the respondents in her New Zealand undergraduate student sample who had been sexually abused had disclosed the abuse, usually to a parent or parent figure (37%) or friend (32%), only 4% disclosed to a community figure, such as police, teachers or social workers. Many respondents (45%) did not disclose abuse until at least one year or more after the abuse stopped, and in some cases abuse was not disclosed for many years. When asked how they felt immediately after disclosure, approximately one-third gave negative responses, such as guilt or shame. In some of these cases the response of the person disclosed to was negative or unsupportive. When asked how they felt about their disclosure now, responses were polarised. Three quarters of respondents gave positive responses, but others reported ongoing guilt, shame or anger. For some participants, negative responses to the question seem largely predicated on a lack of response by the person disclosed to, or little change to the situation. Although this study gave a useful insight into sexual abuse in New Zealand, it may be of limited generalisability due to a rather homogeneous sample (higher than average socio-economic status and largely European culture). A more heterogeneous study conducted by Muir (2001) found that fear of the consequences frequently affected women's ability to disclose. In another local study, Anderson and colleagues (1993) reported that only 7% of sexually abused participants reported the abuse to police or social services, and Romans, Martin and Mullen (1996) suggested that sexual abuse by a family member is much less likely to be reported to police or social services than if the abuser is outside the family. In many cases fears were not unfounded: disclosures were often met with disbelief or rejection on the part of the confidant. This finding concurs

with the international literature; for example, Myer (1985) reported that of 43 mothers who attended an American programme run for mothers of father-daughter incest victims, only half protected their daughters, with 10% taking no action and the remainder rejecting their daughters in favour of their partners. Members of the latter two groups either denied the abuse took place, or blamed their daughters, claiming, for instance, that their daughters were seductive, provocative or pathological liars. Denial of abuse during childhood is often particularly disempowering and engenders a sense of betrayal and may result in the abuse continuing.

Withholding disclosure may be a way to retain control over one's memories and emotions; as Muir (2001) discussed, control (or the lack of it) is frequently an important issue for survivors of abuse. Control may also be maintained through selective disclosure: choosing confidants who maximise confidence about disclosure. It seems possible that disclosure may impact on mental health and potential suicidality, depending on how the disclosure is dealt with. If abuse is disclosed when abuse first occurs, and is appropriately dealt with, the abuse survivor will have the opportunity to take whatever steps she feels necessary to re-establish her emotional equilibrium. On the other hand, if she is unable to disclose the abuse, or it is not dealt with appropriately, she may be at greater risk of feelings of guilt, anxiety, low self-esteem and depression and the abuse may continue. It seems logical that these emotional responses could, in turn, lead to suicidality.

It appears that little research has been done into the impact of childhood or adolescent sexual abuse on defining one's sexuality and future relationships, although clinical evidence suggested that adolescent abuse can alter the process of sexual development (Terre & Burkhart, 1996).

Holguin and Hansen (in press) suggested that in addition to the impact of the abuse itself, the consequences of being labelled as sexually abused may have detrimental effects. They argued that the combination of negative expectations and biases may create a self-fulfilling prophecy, but acknowledged that further research into this area is required. Additionally, the mother's response to a disclosure of sexual abuse is central to her daughter's recovery (Candib, 1999). The majority of mothers, upon disclosure, support their daughters and defend them from the perpetrator. However, a small group of mothers either deny the abuse occurred or blame their daughters.

Furthermore, perpetrators of sexual abuse are rarely identified and even more rarely punished (Candib, 1999); if a girl's mother does not support her she may well receive no support at all. However, Muir's (2001) findings suggested that friends can be an important source of support. A link between delayed disclosure of abuse or inadequate response to disclosure and subsequent suicidal behaviour does not appear to have been researched. However, given what is known about increased likelihood of suicidal behaviour among survivors of sexual abuse, it seems plausible that the addition of a lack of support to deal with the abuse may exacerbate suicidality.

In summary, the evidence suggested that sexual abuse leads to an increased likelihood of depression, anxiety, trauma, and substance abuse, all of which have been associated with suicidal behaviour. While it would be incorrect to say that the majority of survivors of sexual abuse engage in suicidal behaviour, there is no doubt that the risk is increased, and Romans and colleagues' findings suggested that the majority of young women who attempt suicide have been sexually abused. However, Goodyear-Smith (1993) argued that the negative sequelae attributed to sexual abuse may in fact arise from the context in which sexual abuse frequently occurs. Candib's (1999) and Muir's (2001) findings that those who do not disclose abuse or whose disclosure does not result in appropriate responses are at increased risk of distress suggests that the likelihood of subsequent suicidal behavior may be raised in these groups; however, there does not appear to be any research on this topic.

Exposure to Non-Sexual Violence

New Zealand has alarmingly high rates of child abuse (Ministry of Health, 1998). Our death rate for children aged under 14 is the fifth worst of 26 comparable countries (New Zealand Herald, 2001). The Child, Youth and Family Service (CYFS) confirmed 6128 reports of abuse (including sexual abuse) in 1997; in the year 1996/1997, 3901 convictions were obtained for abuse of children: 49% for violence and 48% for sexual offences (Ministry of Health 1998). Hospitalisation for abuse or maltreatment is significantly more common for girls than boys, especially Maori girls. In the decade to 1998, Maori girls aged under 14 had far higher rates of hospitalisation for maltreatment than any other group, although in the last five years the gap between Maori girls and Maori boys has narrowed. From 1988 to 1995 hospitalisation rates for Maori girls aged under 14 have varied from 40 per 100,000 to

200 per 100,000, compared to 50 to 100 per 100,000 for Maori boys. The rates for non-Maori hospitalisations over the same period have been fairly stable: between 10 and 50 per 100,000 for girls, and 10 to 20 per 100,000 for boys (Ministry of Health, 1998).

Physical abuse is associated with a three-fold increase in anxiety disorders and suicide attempts (Ministry of Health, 1998). Adolescent exposure to violence and victimisation is predictive of both depression and hostility, according to American studies (Flannery, Singer & Wester, 2001), which in turn may lead to suicidal behaviour in some cases.

Gibb, Alloy, Abramson, Rose, Whitehouse and Hogan (2001) suggested that childhood emotional abuse contributes to the development of a negative cognitive style, resulting in chronic increases in hopelessness and suicidal ideation. It is argued that with emotional maltreatment negative cognitions are supplied directly to the child by the abuser. In contrast, in cases of physical or sexual maltreatment, the child may not be directly told that she/he is to blame for the abuse. This finding may help to explain Thompson and colleagues' (2000) finding that of five forms of childhood maltreatment studied, including physical abuse and neglect, emotional abuse and neglect and sexual abuse, only emotional abuse increased the odds of a woman making a suicide attempt (when PTSD is controlled for). Lipschitz, Winegar, Nicolau, Hartnick, Wolfson and Southwick (1999) reported the interesting finding that emotional abuse is more strongly associated with suicidal ideation, self-mutilation and suicide attempts than physical neglect or physical or emotional abuse (but not sexual abuse). These findings suggested that a lack of love, encouragement and support may have greater impacts than previously recognised; Lipschitz and colleagues found that emotional neglect may result in low self-esteem which in turn is linked to suicidal behaviour. However, it must be noted that this study was conducted with American adolescent in-patients, the majority of whom were members of ethnic minority groups.

Negative Self-Concept

As observed in various sections of this review, feelings of hopelessness, shame, guilt and powerlessness are discussed throughout the literature on adolescent suicidal

behaviour. SPINZ (n.d.-a) reported that suicidal young people have a sense of not having control over their lives, with little optimism for the future. It has been suggested by Gibb and colleagues (2001) that emotional abuse during childhood may contribute to a negative cognitive style. Townsend Carlson (2001) set out to determine whether there were significant differences in self-concept between 3 groups: non-depressed, non-behaviourally disordered adolescents (comparison group); depressed adolescents and adolescents who had made a previous suicide attempt. Her study confirmed statistically significant differences in both self-concept and stability between the three groups, with the comparison group consistently showing the highest percentage of positive descriptors, both of 'present self' at school, with friends and 'future expected self' while the suicide attempters used more mixed descriptors and the depressed group showed the lowest percentage of positive descriptors. Townsend Carlson suggested that the use of a mixture of positive and negative descriptors by the suicide attempters may be due to increased emotional lability and impulsivity. The suicide attempters showed the lowest percentage of positive descriptors of present self in the domains of ability, appearance, with family, and hoped for future self, followed by the depressed group. These findings appear to concur with Seligman (1974) and Seligman and Peterson's (1986) foundational writings on learned helplessness and depression, which suggested that negative life events and a negative attributional style lead to a sense of helplessness and depression via a belief that the individual is powerless/helpless to effect positive change. This in turn can lead to hopelessness.

Beck (1986) and others have argued that hopelessness is a stronger predictor of suicidality than depression. It is difficult, if not impossible, to find hopeful depressed people. More recently, Kapci and Cramer (2000) found that negative attributions for negative events combined with a high number of negative life events predict depression. It appears that hopelessness has a cumulative effect, rather than simply correlating to depression.

Non-Suicidal Self-Harming Behaviours

A number of self-harming behaviours that are not suicidal may be linked to suicidal behaviour. These are often considered risk factors, but may also be viewed as correlates, rather than having a causal relationship.

Orbach, Stein, Shani-Sela and Har-Even (2001) noted a growing research interest in body experiences which may facilitate self-destructive behaviour. They suggested that negative life events can result in alteration of perceptions, feelings and experiences of the body resulting in body hate, bodily detachment, sense of lack of control and loss of bodily boundaries. Orbach and colleagues suggested that these perceptions and experiences may translate into self-destructive behaviour. They cite previous studies by Orbach and Mikulincer (1998) that found that suicidal adolescent inpatients received lower scores on scales of body image, feelings and attitudes when compared to non-suicidal inpatients and 'normal' controls.

Orbach and colleagues (2001) studied 15 male and 22 female teenagers who had been hospitalised for suicide attempts. Controls consisted of 30 non-suicidal psychiatric patients (patients were diagnosed according to DSM criteria) and 30 community volunteers who were asked to complete a questionnaire to check for suicidal intentions. Self-mutilators were excluded from the study. Orbach and colleagues (2001) found that attitudes and feelings toward the body, protection of the body and body aberration differentiated between the suicide attempters and the controls. A sense of lack of control over the body also distinguished the attempters from the normal group, but not from the inpatient controls, although a discrepancy in the scores between the two hospitalised groups is noted. As a result, Orbach and colleagues suggested that attitudes about life and death are interwoven with attitudes, feelings and experiences of the body; lack of enjoyment of life and death wishes are strongly associated with a hateful relationship and lack of comfort with the body. While this result seems unsurprising in itself, it has several implications for the present study. The next two sections explore ways in which dissatisfaction or discomfort with the body may translate into self-harming behaviours and how they in turn intersect with suicidal behaviour.

Eating Disorders

In the previous section and the section on gender, distress over one's body has been discussed. In addition to suicidal behaviour, this distress can manifest as an eating disorder. Puberty is associated with weight gain for most girls. This usually occurs in a culture that upholds slenderness as the female beauty ideal (Wolf, 1991). As

discussed by Striegel-Moore and Cachelin (1999), the physical developments of adolescence conflict with western cultural norms of beauty. Concerns about physical appearance can become all-consuming. Lawrence (1979) argued that a control paradox is central to anorexia; anorexics perceive themselves as out of control, powerless and denigrated as women, and struggle for control through attempts to transcend the body and to achieve self-respect through self-denial. However, results of studies into a relationship between gender role identification or femininity and disordered eating have been mixed.

Eating disorders typically begin during adolescence. Bushnell (1997, citing Wells, Wells & McKenzie, 1986 and Wells, Bushnell and Hornblow, 1989) reported that while 14 percent of Auckland girls aged 13 to 17 years exhibited the disturbed attitudes to eating and food that suggested a potential eating disorder, in a Christchurch study three women per 100,000 general population had experienced anorexia nervosa. Bulimia nervosa was rather more common, with a lifetime prevalence of 1.9%. These rates are considerably higher than rates of hospitalisation for suicidal behaviour. When one leaves aside the criterion of a DSM diagnosis, disordered eating patterns are common. Among Christchurch women aged 18 to 44, lifetime experience of recurrent binge-eating was reported at 22.5% (Bushnell, 1997).

Striegel-Moore and Cachelin (1999) contended that the aetiology of eating disorders is multi-factorial, involving personal, familial, social and biological variables in a complex interplay. In this regard the model of risk factors is similar to that of suicidal behaviour. Striegel-Moore and Cachelin discussed a model of risk and protective factors that includes the social and cultural context, family context, personal attributes, life events, self-image and body image. As with suicidal behaviour, a history of abuse is a common antecedent to eating disorders. Alderman (1997) reported that at least one-third of those with eating disorders have experienced some type of trauma, such as sexual abuse. This may be coupled with a sense of social isolation, social anxiety, impoverished relationships and lack of social support (Striegel-Moore & Cachelin, 1999). Social support, personal development and connection with others are identified by Striegel-Moore and Cachelin as integral aspects of recovery from eating disorders.

Polinska (2000) suggested that between 26% and 40% of anorexics and bulimics also mutilate themselves, while Favazza, DeRosear and Conterio (1989) reported finding that 50% of self-mutilators have or have had an eating disorder. This relationship is discussed below, in the section on self-mutilation.

Self-Mutilation

As mentioned in chapter one, definitions of self-mutilation have been problematic. In New Zealand, the Ministry of Health regularly produces figures on 'deliberate self-injury'; these figures are frequently used to inform discussions of suicidal behaviour. However, no attempt was made to discuss the intentions or motivations behind these injuries. As Alderman (1997) noted, it is often difficult for observers to distinguish between injuries resulting from self-mutilation and some of those caused by a suicide attempt. In some cases, such as hanging or gunshot, it may be reasonably safe to assume intended lethality; in other cases, such as arm-cutting, the intention is less clear.

Although this thesis focuses on intentional suicidal behaviour rather than self-mutilation, the frequent conflation of the two, combined with the possibility that self-mutilation may be a precursor to active suicidal behaviour in some cases, suggests that self-mutilation is an appropriate topic for discussion here. There does not appear to be any local literature on self-mutilation; therefore the following discussion is drawn from American and British material. It is not known how well these findings, theories and models fit the phenomenon in New Zealand.

Using a broad definition of self-harm that encompasses tattooing and body-piercing through to limb-amputation, but not suicide attempt, Favazza (1996) discussed a variety of functions of self-mutilation. These range from seeking spiritual enlightenment, or a sense of identity, through to a morbid type of self-therapy. Favazza does not include death as an intended outcome of the behaviour, although in some cases death may result. Adshead (1997) suggested that low-lethality/high repetition deliberate self-harm is a re-enactment of previous trauma, in which the individual internalises the original trauma and acts sadistically towards the self. Cutting is arguably the most common form of this behaviour. The individual may not experience pain, and often the behaviour itself provided a sense of relief from internal tension (Levenkron, 1998). The skin is a border between the outer world

and the inner world, the environment and the personal self. Cutters first are able to verify that they are alive, and then they are able to focus attention on their skin border and to perceive the limits of their bodies.

Both suicidal behaviour and self-mutilation are ways of dealing with psychological pain. However, self-mutilation is qualitatively different from suicide. The intended outcome of the behaviour is clearly not to die, but may be to seek support or attention. In the case of suicidal behaviour, the intention is death; a permanent solution rather than an attempt to adapt the psychological state. Self-mutilation is not intended to produce life-threatening injuries; the goal is to feel better, rather than to not feel at all. Self-mutilation is not a mild form of suicide attempt (Alderman, 1997). The literature underscores this difference, as Walsh and Rosen (1988) discussed: self-mutilators seldom intend to die, and there is often very little risk of dying.

Walsh and Rosen discussed four central points of difference between self-mutilation and suicidal behaviour: the intent of the perpetrator; the physical damage that results; the frequency or chronicity of the behaviour; and the methods selected. "His [sic] behaviour is actually counter-intentional to suicide rather than suicidal" (Ross & McKay, 1978, p. 15). Suicide is characterised by unendurable psychological pain, seeking a solution to an overwhelming problem and the goal of cessation of consciousness. Self-mutilation is characterised by intermittent, escalating psychological pain, seeking short-term alleviation and the temporary alteration of consciousness (Walsh & Rosen, 1988).

People who engage in high-repetition/low-lethality behaviour, and those who attempt suicide (that is, engage in high-lethality behaviour) share some characteristics. For example, they are usually female, aged in their teens and early twenties, and have a history of sexual abuse (Pritchard, 1994). Stanley, Winchel, Molcho and Simeon (1992) suggested that serotonergic dysfunction underlies all types of behaviour on the non-fatal suicidal behaviour continuum. However, there are general differences. Self-mutilators often fit a diagnosis of borderline personality disorder (see Adshead, 1997, for example), while those whose intention is suicide are more likely to suffer from depression (Pritchard, 1994). However, as discussed earlier, at least in the case of borderline personality disorder, the reasoning behind diagnoses seems circular.

With regard to the behaviour itself, it appears that in the former group, the act itself provided the relief, while in the latter, it is the consequences of the act that are sought. In New Zealand, it appears that for the purposes of statistics self-injurious behaviour that results in hospitalisation is usually assumed to be a suicide attempt (or at least no distinctions are made in subsequent reports), although it may well be that some cases of cutting were not preceded by suicidal intent.

It should be noted that previous research suggested that self-mutilators and people who attempt or commit suicide are not necessarily mutually exclusive groups. Walsh and Rosen (1988) discussed a study of adolescent patients undergoing treatment for self-mutilation, in which 30% of mutilators had also made recent suicide attempts, although the intent of the self-mutilation was not suicidal. The self-mutilators who also had made suicide attempts were significantly more likely to have been sexually abused as a child, to have recently suffered the loss of a significant other, or to experience frequent conflict with peers, than the self-mutilators who had not made suicide attempts. A history of sexual abuse was found to be most significant in discriminating between self-mutilators who had also been suicidal and those who had not, while peer conflict was the least significant. Walsh and Rosen suggested that self-mutilative behaviour is intended to reduce tension, depression or anger. When the behaviour ceases to achieve these results the individual becomes increasingly desperate, escalating to becoming suicidal. At that point a suicide attempt is made, in order to achieve permanent escape from an intolerable situation that seemingly could not be modified and that the self-mutilation had failed to ameliorate. Walsh and Rosen concluded that self-mutilation is a distinct class of behaviour; however, although self-mutilators who become suicidal are in the minority, there is a possibility of this behaviour occurring, especially in those who have been sexually abused. Favazza and Conterio (1989) stated that “*In desperation over her inability to control her self-mutilative behaviour* [the] typical subject has attempted suicide by drug overdose” (p. 283, *italics added*). Overall, while some overlap is acknowledged, self-mutilation and suicidal behaviour are seen as distinct behaviours.

Self-mutilation is usually a secret behaviour, largely because of fear of others’ reactions, according to Alderman (1997), although recent discussion such as that by Gerrard (2002) suggested that self-mutilation is becoming increasingly acceptable among adolescent females. The onset of the behaviour most commonly occurs in

adolescence and seems to peak in the mid-twenties, but the incidence is unknown. Nichols (2000) suggested that the prevalence in the general American population could be as high as 1.4%, and reported that 12% of American college students admitted deliberately injuring themselves (gender not specified). It appears to be more common in females, with Nichols reporting that 85 to 95% of self-mutilators are female, although Alderman argued that the behaviour is not uncommon among male prison inmates and mental hospital patients; women who self-mutilate are simply more visible to health professionals and the wider community. The majority of self-mutilators have a history of physical, sexual or emotional abuse, and Deiter, Nicholls and Pearlman (2000) reported that those with a history of childhood abuse have greater difficulty in maintaining a sense of self-worth or sense of connection to others. Many mutilators are unsure of how they began to hurt themselves, but the most common form is cutting, followed by burning. A small number of mutilators seem to begin the behaviour after being exposed to it in an institution such as a psychiatric ward or welfare institution; individuals who mutilate in these settings may have the behaviour reinforced through secondary gains such as increased staff attention (Alderman, 1997). Another theory of how individuals who self-mutilate are rewarded is biological: when an injury occurs endorphins are released to minimise pain. The release of endorphins also stimulates pleasurable sensations and a sense of well-being. Alderman discussed research that suggested that people who self-mutilate may have a biological dysfunction involving decreased levels of endorphins. However, at this point research on the topic is in its infancy.

Gardner and Chowdry (1985) discussed self-mutilation in patients with borderline personality disorder, reporting that patients often recount an absence of pain during self-mutilation, instead experiencing numbness or dissociation, frequently resulting in a dramatic relief of underlying dysphoria which is replaced by a clearing of thoughts and state of calm. However, they reported that the initial experience of relief may be followed by feelings of self-hate or guilt; Alderman (1997) agreed with this finding. She discussed a first stage of a great sense of relief, produced by the release of endorphins, and asserted that this is the reason self-mutilation is self-reinforcing. However, this is followed by feelings of guilt, shame and the return of the feelings that precipitated the mutilation, perhaps resulting in a repetition. Attempts to conceal the behaviour are usually made. The dissociative quality of the experience may include aspects normally attributed to multiple personality disorder or

dissociative identity disorder (DID), including depersonalisation to such an extent that the individual feels 'as if another person has taken over'. Other individuals overuse medication to terminate dysphoric states, in some cases resulting in addiction. However, Alderman (1997) suggested that BPD may be diagnosed inappropriately. Of all the possible psychiatric diagnoses, self-mutilation is most often associated with BPD; it is also the only diagnosis that specifically identified self-injurious activities as a diagnostic criterion, other than trichotillomania (pulling out one's hair) and sexual masochism. Therefore, according to Alderman, clinicians tend to diagnose individuals who deliberately harm themselves as having BPD. Kirk and Kutchins (1992) concurred with this opinion and provided an extensive critique of the diagnostic procedure for BPD.

Self-mutilation is also associated with dissociative identity disorder (DID), as alluded to by Gardner and Chowdry (1985). Dissociative identity disorder is usually linked with trauma experienced as a child, particularly severe sexual or physical abuse (Alderman, 1997). Self-mutilation serves several functions for individuals with DID, according to Alderman. As well as providing a release of emotions and in some cases a means of expression, self-mutilation may be used to control dissociation. It may also be used to prevent or induce the emergence of an alter (alternate identity), through the physical sensations experienced during an act of self-mutilation. Violence may also occur between the alters, as a violent act perpetrated by one on another, or as a result of an inner dialogue between alters.

There also appears to be a relationship between eating disorders and self-mutilation. Alderman (1997) reported on research that most women who mutilate themselves also have or have had an eating disorder (no reference given); Favazza and Conterio (1989) also described the typical self-mutilator as having had an eating disorder. Alderman suggested that both may stem from a need for coping mechanisms or means of gaining control. Both can provide both a way of coping with internal pain, a release of tension, of expressing one's psychological state and to regulate dissociative states. Alderman posited that rather than a causal relationship, eating disorders and self-mutilation occur as a result of common sources such as trauma as a dependent variable.

Alderman (1997) also reported on self-mutilation occurring as a re-enactment of previous abuse. She suggested that there are a variety of mechanisms by which this may occur. The abuse may be re-enacted in order to establish a sense of control. A child being abused probably has very limited control of the situation; as an adult the individual is able to control how, when and where to hurt oneself, and when to stop. Alderman also discussed replicating abuse as part of a post-traumatic stress flashback. As discussed above, DID may result in mutilation. For others self-abuse may be a way of alleviating shame or punishing oneself. The individual may have little or no cognisance of the reasons for engaging in the behaviour.

'Taking control' is a common theme in Alderman's book. She discussed control as "an essential component in each of our lives, and perceiving that we have control is indisputably important to our mental health" (1993, p. 50). She suggested that self-mutilation is a way to control one's physical being, and that episodes of self-mutilation are triggered by a sense of lack of control. By engaging in self-mutilation, the individual is taking control of her emotional states. Self-mutilation may also be used as a way to control physical experiences, to avert dissociation or alter consciousness, or to discipline the body. Mutilation may also function to disrupt obsessive or intrusive thoughts. "Control allows us to feel healthier, happier, more secure and less anxious...without perceived control we would feel...hopeless, helpless and depressed" (Alderman, 1997, p. 51).

While self-mutilation has been associated with mental illnesses such as personality disorders, recent reported suggested that mutilation may be becoming both increasingly common and increasingly normalised among teenage females. Margot Waddell, a British therapist (cited by Gerrard, 2002), discussed cutting as a source of relief, reassurance that the cutter is 'real', a way of coping with emotional pain, and providing the thrill of breaking a taboo. And, Waddell argued, cutting can be a casual act, not dissimilar to experimenting with drugs or sex, and many cutters are mimicking their peers rather than displaying serious mental illness. This analysis has echoes of the late 1970s/early 1980s 'punk' and 1990s 'grunge' cultures. For example, popular musicians such as Iggy Pop and the Sex Pistols' Sid Vicious often cut themselves on stage in the late 1970s, and in the 1990s Rich Edwards, a member of the Manic Street Preachers, carved '4 REAL' into his forearm. The fates of these performers varies widely: Iggy Pop still performs regularly, as does former Sex Pistol

John Lydon, but Vicious died of a heroin overdose in 1980 while under investigation for the murder of his girlfriend, and Edwards has been missing for some years. Interestingly, most of these very public mutilators are male.

Alderman (1997) noted that most individuals stop mutilating by the time they reach their thirties, regardless of involvement in therapy or other interventions. She hypothesised that self-mutilation is something that most individuals simply outgrow, as they develop beyond the emotional turbulence and pressures of adolescence and early adulthood, and learn other coping skills. She also noted that most self-mutilators who seek professional help find the experience dissatisfying. She suggested that many therapists and clinicians overlook the issue out of inexperience, ignorance or discomfort, so it is left to the individual to broach the subject. However, many individuals have difficulty in disclosing their mutilating behaviour because of shame, or fear of repercussions such as admission to a psychiatric ward. Additionally, Alderman argued that many clinicians are simply poorly prepared to deal with the issue. Stanley, Geamerooff, Michalson and Mann (2001) reported that emergency room doctors frequently meet self-mutilators with condemnation as 'attention-seekers', when they should be referred for further help and reassured. Further, Stanley and colleagues suggested that clinicians tend to see suicide attempts by known self-mutilators as extreme self-injury and manipulative attention-seeking rather than as serious attempts. However, their research suggested that there is no difference in the lethality or number of attempts made by suicide attempters who also self-mutilate when compared to suicide attempters who do not mutilate. Indeed, self-mutilators seem to experience greater frequency and duration of suicidal ideation than non-mutilating suicide attempters.

In summary, although the possibility of suicide attempts by self-mutilators is acknowledged, the literature describes self-mutilation as distinct from suicidal behaviour. This distinction encompasses motivation (temporary relief and attention-seeking compared to permanent relief), intention (release of negative emotions compared to death), lethality, frequency and mental health diagnoses (BPD compared to depression).

Substance Abuse

As mentioned at the beginning of this chapter, substance abuse has been linked to suicidal behaviour. For example, the Canterbury Suicide Project has found that individuals who meet DSM criteria for cannabis abuse or dependence are 10 times more likely to make a medically serious suicide attempt than individuals who did not meet the DSM criteria (Beautrais, 1997). Substance abuse is often discussed as a risk factor. However, this implies a causal relationship; that it is a characteristic that may lead to suicidal behaviour. While it seems clear that there is a correlation between the two, with substance abuse frequently occurring concurrently with suicidal behaviour, it is possible that substance use occurs as a result of suicidal feelings, as an attempt to self-medicate against, for example, depression caused by other factors. Moreover, substance use is not uncommon among young people; indeed statistics suggest that quite high levels of abuse are often socially acceptable and even expected among youth (Wilkins, Casswell, Bhatta, & Pledger, 2002). For these reasons it is suggested (by Beautrais, 1997, for example) that although substance use frequently occurs alongside suicidal behaviour it is not a risk factor in itself. However, it is acknowledged that suicidal young people may engage in the use of substances more frequently or at higher levels than youth in general. Beautrais, Joyce and Mulder (1994) found that approximately half of those who completed or attempted suicide in their study had histories of substance abuse, compared to 10% of the control group.

Substance use is increasingly common among young women (Wilson, Moewaka Barnes, & Woolgrove, 2002). Approximately 85% of respondents in the most recent New Zealand National Alcohol Survey reported that they had consumed alcohol within the previous 12 months, with the greatest volume being consumed by the 18 to 25 age group (both men and women). While women drink less than men, both in terms of frequency and volume, their consumption appears to be increasing (Habgood, Casswell, Pledger & Bhatta, 2001). Those most likely to consume large amounts of alcohol are the young. There has been a marked increase in the quantities consumed during a typical drinking session (Habgood et al., 2001), as well as an increase in the frequency of such occasions. The proportion of women aged 15 - 17 who drank enough to feel drunk at least monthly increased from 33% in 1998 to 50% in 2001, and the proportion of women in this age group who drank four or more drinks in one sitting at least once a week increased from 15% in 1998 to 28% in 2001 (Wilkins et al., 2002).

Marijuana is the third most commonly used drug in New Zealand (after alcohol and tobacco), and the most popular illegal drug. In 1998, 44% of New Zealand women reported that they had tried marijuana; in 2001 the proportion had increased to 48%. Among the 15 - 17 age group the proportion who have tried marijuana increased from 26% in 1998 to 38% in 2001. In 2001, 29% of women aged 15-24 reported using marijuana in the last year. Frequent use¹⁹ among women in the 15-17 age group also increased, from 0% in 1998 to 4% in 2001.

Use of drugs other than alcohol, tobacco and marijuana is most common in those aged under 35. Approximately twice as many men as women reported use of illicit drugs other than marijuana in a 1998 study (Field & Casswell, 1999). However, this gender gap has diminished over recent years; in 1998, 17% of women had used 'other drugs' in the previous 12 months while in 2001 this figure had increased to 20%; the rate for men remained the same. The largest increase was in the 15 to 24 age group (Wilkins et al., 2002).

Multiple use of illegal drugs appears to be increasing in New Zealand. Wilkins and colleagues (2002) reported that the proportion of women using three or more illicit drugs in the last year has increased, particularly in the 15-24 age group. In 1998, 2% of women reported using three illegal drugs in the past year. In 2001, 4% of females reported use of three illegal drugs in the past year, with 11.4% of females aged 18-24 reporting past-year use.

While young New Zealand women's substance use is increasing alongside rates of suicidal behaviour, a causal relationship between the two cannot be assumed. Beautrais (1997) suggested that many individuals who abuse cannabis and engage in suicidal behaviour are more likely to have a history of socio-demographic and childhood disadvantages such as low socio-economic status, alcohol problems, childhood sexual abuse and poor parental support. These individuals are at increased risk of suicidal behaviour regardless of cannabis use. Beautrais' conclusion is that cannabis does not, in itself, place an individual at increased risk of suicide. Although

¹⁹ A frequent user is defined in this survey as one who smoked marijuana on 10 or more occasions in the last month.

not discussed by Beautrais, it seems possible that alcohol problems may also be a co-occurrence rather than a cause of suicidal behaviour.

Other Internalising and Externalising Behaviours

Both internalising behaviours (such as social withdrawal) and externalising behaviours (such as disruptive 'acting out') have been used to predict past suicidality among adolescents (Langhinrichsen-Rohling et al., 1998), and conduct disorder has been linked to suicidal behaviour, as discussed earlier in this chapter. Yet depression, suicidal ideation and suicidal behaviour are usually associated with internalising behaviour such as social withdrawal, especially among young women. This tendency may be given as an explanation for depression being overlooked by parents and other caregivers. However, young women also exhibit externalising behaviours. King and colleagues (2001) reported that risk-taking or externalising behaviours such as fighting, smoking, unsafe sexual activity and recent drunkenness were associated with suicidal ideation and attempts in their American study, even after controlling for socio-demographic factors. However, the role of gender is not discussed in this study. Although Vannatta (1997) found that school misconduct and aggressive behaviour were most strongly associated with increased likelihood of suicidal behaviour in American boys, over-the-counter drug and cigarette use was a leading predictor of suicidal behaviour in females (odds ratios of 37.8% and 34.5% respectively), although school misconduct resulted in an odds ratio of 26.7% for girls, compared to 43.2% for boys. Slap and colleagues (2001) noted that although cigarette smoking has been associated with suicidal behaviour in several studies, it appears to be an indicator of risk rather than an independent predictor of suicidality. Once again, it is unknown how relevant these findings are to young New Zealanders. Tobacco has been identified as the second most commonly used drug in New Zealand, after alcohol (Field & Casswell, 1999), but World Health Organisation data seems to indicate similar smoking rates in women in the United States and New Zealand, although this varies markedly in various sub-groups, such as ethnicity and income (World Health Organisation, 1997). Given that so many young women smoke (approximately one in three), this does not appear to be a useful tool for predicting suicidal behaviour in the community, but it is a far more observable risk indicator than over-the-counter drug use.

Summary

A range of social factors have been identified as contributing to suicidal behaviour. These range from the macro-social, such as gender and ethnicity, to the interpersonal, such as a lack of social support. It is generally agreed that normally a combination of factors lead to suicidal behaviour; for example, although sexual abuse is not uncommon in young women who attempt suicide, it is insufficient as a cause of suicidal behaviour in itself; if accompanied by family dysfunction the risk of suicidal behaviour increases. While it has been acknowledged that women are at greater risk of several risk factors, notably depression, and depression is diagnosable in 90% of suicide attempters, the role of gender in suicidal behaviour has received relatively little attention when compared to, for example, psychopathologies.

Although a number of factors such as unemployment, and drug abuse have been discussed as precursors to suicidal behaviour, recent research suggests that these are, in fact, correlates rather than causal factors.

Cessation

In comparison to the section on initiation and risk factors, the sections on cessation and prevention are relatively brief. This reflects the status of the literature and research: to date, the major focus in suicidology has been on establishing risk factors. Studies and discussions on recovery, prevention and intervention are comparatively limited. As Canetto (1995) noted, the literature on interventions rarely deals with primary prevention; rather the focus is on secondary prevention (reduction of distress following suicidal behavior) and tertiary prevention (prevention of repetition). In addition, many interventions are deficit-based; for example, if it is ascertained that an individual lacks social support, interventions may focus on bolstering social skills. However, there may be other issues that exacerbate the deficits, or have arisen because of them. For example, a person who lacks social networks may have concerns about emotional betrayal or alcohol use that social skills training will not necessarily address.

The following pages provided an overview of current research regarding cessation by briefly discussing some factors impacting cessation and recovery and interventions currently in use and barriers to treatment and recovery.

Anthony (1993) pointed out that ‘recovery’ is a problematic term when applied to mental illness. Individuals who continue to experience some indications of illness can be said to have recovered, since “Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness” (p.14). The concept of recovery is especially nebulous when we recognise that it is possible to display some of the symptoms or characteristics of the ‘illness’ when ‘well’. The ‘illness’ that most commonly underlies suicidal behaviour, depression, is after all, a normal occurrence in every person’s life to some degree.

In the case of suicidal behaviour, we may have a more tangible measure of recovery – that of cessation. When an individual has ceased to engage in suicidal behaviour, we may say that she has recovered. However, this definition is not clear-cut either. How much time has to elapse without the behaviour occurring before we can say that a person has ‘recovered’? Any time period chosen by a researcher is unavoidably arbitrary. In this thesis, two measures of recovery have been used: a length of time from the last suicide attempt, and the participants’ own identification as having recovered. The latter measure has been given primacy over the former; if a prospective participant did not feel that they had recovered, they were not considered suitable for participation, regardless of the time lapse since the last instance of suicidal behaviour.

Social Support Networks

As discussed in more detail in the section on risk factors, a lack of social support has been identified as a contributing factor to suicidal behaviour. As a result of a study of 40 New Zealand men and women who had recovered from mental health problems, Lapsley and colleagues (2002) reported that the support of others was the most commonly identified factor in facilitating recovery. Family members and mental health workers were the most common source of support, with each being

mentioned by more than half the participants. More than a third of participants mentioned friends and over half received help from groups such as support groups and therapy groups. Support took the form of being physically present, conveying faith in recovery, active practical support such as looking after children and challenging destructive behaviour. It should be noted, though, that this study involved both men and women, of all ages, and with a variety of 'mental illnesses' that may or may not have involved suicidal behaviour.

Increasing Self-Esteem

Self-esteem has been mentioned in this review in relation to depression, conduct disorder, ethnicity, sexual abuse, gender and socio-economic disadvantage.

Overholser, Adams, Lehnert, & Brinkman (1995) reported that low self-esteem was linked to female gender and related to higher levels of depression, hopelessness, suicidal ideation and likelihood of previous suicide attempts in their study of 542 American adolescent psychiatric inpatients. They concluded that efforts at intervention should address self-esteem deficits. The findings of this study may not be generalisable to New Zealand women who are not psychiatric inpatients.

Nonetheless, low self-esteem is clearly identified in the literature as an important issue in suicidal behaviour, and it seems highly likely that it is associated with non-fatal suicidal behaviour in New Zealand women. Therefore, building self-esteem could be an important factor in cessation and recovery.

Coping Skills

Coping may be defined as changing cognitive and behavioural efforts to manage external or internal demands that are perceived as draining personal resources (Lazarus & Folkman, 1984). As such, coping skills may be useful tools for dealing with personal distress and managing stressful situations that may impact upon suicidality. According to Lazarus and Folkman, coping strategies can be grouped into two types, problem-focused and emotion-focused. Problem-focused strategies direct attention towards the problem in an effort to find ways of solving it.

Emotion-focused coping comprises efforts to ameliorate emotional distress. The type of strategy chosen depends in part on the individual's perception of the problem's mutability: when the individual believes the problem is unalterable, emotion-focused coping is more likely to be utilised, while a problem-focused

strategy is likely to be chosen if the issue is appraised as changeable. A third type of strategy, avoidance, has also been observed (Edwards & Holden, 2001). Typical avoidance strategies include distraction and social diversion.

As discussed by Edwards and Holden (2001), research has suggested an association between coping strategies and suicidal behaviour. Suicidal adolescents have been found more likely to choose emotion-focused strategies to deal with stressful situations, while problem-focused strategies are associated with lower suicidality. Individuals who are depressed or at risk of suicide tend to be more likely to use avoiding strategies than others (Edwards & Holden, 2001). Depressed participants in Spirito, Francis, Overholser and Frank's (1996) study of American adolescents used social support as a coping mechanism less often and social withdrawal and self-criticism more often than non-depressed participants. Greater distress appears to lead to less problem-solving and more cognitive avoidance.

Pollock and Williams (2001) argued that suicide attempters tend towards dichotomous thinking and tend to be inflexible and rigid in their thinking leading to difficulty in changing their problem-solving strategies. Citing Marx, Williams and Claridge (1992), Pollock and Williams suggested that inability to generate effective solutions to problems is due to a deficit in the ability to remember previously used successful problem-solving strategies. Pollock and Williams describe a relationship between over-general autobiographical memory and ineffective problem-solving skills, suggesting that in suicide attempters effective problem-solving is compromised by lack of specific autobiographical recall; "individuals who have difficulty in generating effective solutions to interpersonal problems ... also tend to have the greatest difficulty retrieving specific memories" (p. 394), therefore, they do not have a memory store of successful strategies. The authors suggested that recognition of this is important in the counselling process; skills for the development of new strategies may be an important part of the recovery process. In contrast, Wilson, Stelzer, Bergman, Kral, Inayatullah and Elliot (1995) reported that twenty Canadian suicidal adolescents did not show evidence of rigid thinking or lack of ability to generate solutions to problems. However, although they were able to generate as many positive problem-solving strategies as the control group, they actually used fewer and were more likely to use maladaptive coping strategies. They also reported

more severe recent life stress, and had inaccurate appraisals of their ability to control stressful events, compared to controls.

McLeavey, Daly, Ludgate and Murray (1994) have reviewed the effectiveness of interpersonal problem-solving skills training in 39 people aged 15-45 admitted to an American hospital. Although both the group that received the training and the control group demonstrated a reduction in presenting problems and hopelessness, the group that received the training reported increased interpersonal problem-solving skills, perceived ability to cope with problems and self-perception. These gains were maintained at six-month follow-up, and at one year there was a reduction in repeated suicide attempts among the experimental group.

Given the significance of factors external to individual psychopathology, it is interesting to note that almost all the interventions discussed in the literature are based on individual treatment, with the remainder incorporating some level of family therapy. While factors such as sexism and racism do not readily lend themselves to intervention, it may be feasible to address some social factors that exacerbate stress and depression, such as unemployment or lack of support of bi- or homosexuality, through practical measures.

Clinical Intervention/Treatment

Much of the literature on prevention and intervention focuses on secondary and tertiary strategies for dealing with people who have engaged in suicidal behaviour, such as management guidelines for doctors and schools, medication and psychotherapy. It is generally agreed that primary prevention works best, particularly when focused on distal causes rather than immediate precipitants (Canetto, 1995). However, in the literature available to me, there is little discussion of programmes that address risk factors for suicidal behaviour in young women, such as sexual abuse and problematic gender socialisation.

SPINZ (2000) suggested that many young people are reluctant to confide in their families or external support systems. Reasons given for this include fear of stigma, embarrassment or shame, a belief that nothing can help, concerns regarding confidentiality, lack of awareness or difficulty accessing resources, negative previous

experiences, cultural or family values. However, SPINZ suggested that some may confide in their peers. Canetto's research (1995) found that in America, telephone suicide prevention services are the most used prevention strategy. Spirito, Boergers and Donaldson (2000) also noted that clinicians and family members tend to assume that adolescent suicide attempts are manipulative, whereas most adolescents report that they are motivated by a wish to escape or die. It seems possible that being treated as an 'attention-seeker', rather than having suicidal behaviour taken seriously, may be an aversive experience for some, resulting in a desire to avoid further contact with those that conferred the judgement.

In addition, it is unclear what forms of intervention and treatment are most effective (Burns & Patton, 2000; Canetto, 1995; van der Sande, 1997). Miller and Glinski (2000) reviewed the research on the small number of randomised clinical treatment trials among suicidal adolescents including several medications and Dialectical Behaviour Therapy (DBT). They report that in general control conditions (placebo or 'treatment as usual') are as effective at reducing suicidal behaviour as the experimental conditions. Similarly, van der Sande and colleagues (1997) reviewed 12 randomised controlled trials of interventions conducted between 1980 and 1995 with adult suicide attempters and report that although several promising trends were observed, a temporary significant reduction of suicidal behavior was reported in only two. Van der Sande and colleagues also conducted their own trial intervention but did not achieve significant results. Burns and Patton (2000) reported that their inventory of Australian suicide prevention strategies was not able to determine efficacy for most as evaluations were either unavailable or unclear. Spirito and colleagues (2000) review a number of intervention techniques and conclude that although the available interventions have received little empirical support, it is possible to formulate some treatment guidelines. These include:

- During the crisis phase, regular assessment of risk should be undertaken, including intent, availability of means, and provision of 24-hour back-up support.
- The individual's family should be educated as to warning signs and encouraged to restrict access to means and increase supervision
- Establish a working alliance with the person at risk, perhaps negotiating a 'no suicide' contract with her/him
- Maintain an empathic but objective view of the at risk individual

- Continually reassess hopelessness
- Assess and modify problem-solving deficits

In addition to the reviews and meta-analyses discussed above, a number of individual therapies are reported in the literature. However, it is often difficult to ascertain their effectiveness due to methodological issues and/or lack of detail of the specific techniques used. In addition, the evaluation of specific individual therapies is beyond the scope of this thesis. While there is some suggestion in the literature accessed for this review that suicide-related interventions should be gender-specific (Canetto & Lester, 1995; King, Preuss & Kramer, 2001; Langhinrichsen-Rohling et al., 1998); this topic appears to have received very little attention to date.

Hatcher (1997) reported that self-injurers who seek medical attention could potentially be accessing an opportunity for help that is important, as they often are not in contact with mental health services. However, the provision of hospital services in New Zealand is unplanned and disorganised, with most Crown Health Enterprises having no written guidelines for their management. It should be noted that this research was conducted in 1995, before the advent of the New Zealand Youth Suicide Prevention Strategy (1999), which specifically targets crisis support and treatment. Currently, most people who present at a hospital for a suicide attempt are referred for a psychiatric assessment; this may or may not result in ongoing counselling or therapy, or referral to other services. In addition, main centres have Crisis Assessment and Treatment Teams available to respond to emergencies. The availability of other services depends on the location, but hospitals have mental health teams available, which usually are multi-disciplinary, including a psychologist and/or psychiatrist and social worker.

Crockwell and Burford's (1995) article is unusual in that it discussed the lived experiences of three adolescent females who have made suicide attempts, using a narrative approach. Recurring themes in these young women's stories are feelings of betrayal, wanting to be heard and understood, feeling that the only thing they have control over is whether they live or die and the importance of basic qualities such as honesty, genuineness, respect and the opportunity to build trust over time in relationships with counsellors, therapists or 'helpers'. Clearly there are implications

for family, friends and members of the helping professions who wish to aid these young women on a path to cessation.

Treatment programmes and interventions that are effective for Maori is of major concern in New Zealand. Health-promotion initiatives that have been shown to be effective with non-Maori have been shown to have less impact on Maori health outcomes. A number of writers have emphasised the need for both the message and the messenger to be identified as Maori (Ropiha, 1993; Rada, 1997; Pihema, 1989 cited by Wilson and colleagues (2002). Rada also discussed the prestige of the messenger as an influence on perceived trust and credibility, which in turn impact health decisions.

Dialectical Behaviour Therapy. Dialectical Behaviour Therapy (DBT) was developed by Marsha Linehan in the early 1990s to address self-harming behaviour in women with borderline personality disorder (Linehan, 1993). DBT is a cognitive behavioural treatment that integrates individual therapy with skills training. It combines training in coping and problem-solving skills, for example, with counselling techniques. Over recent years it has been used in America in the treatment of women with BPD and eating disorders (Safer, Telch, & Agras 2001; Telch, Agras, & Linehan 2000), self-mutilation (Alper & Peterson, 2001) and suicide attempts (Miller & Glinski, 2000; Rathus & Miller, 2002), and results appear to be very promising for the former two groups. However, results with suicide attempters appear less conclusive (compare the positive results of Rathus & Miller, 2002 with the inconclusive results of Miller & Glinski, 2000 for example); it appears that the therapy may be more effective with suicidal adults than adolescents, although more research is required. The therapy is currently being trialled and evaluated at Health Waikato's Mental Health Service.

Non-compliance

American research suggested that 'non-compliance', that is, discontinuation of therapy or counselling without the therapist's approval, is a difficulty that therapists and counsellors working with young suicide attempters frequently face. Reviewing the literature, Spirito and colleagues (2000) reported that approximately 40% of adolescent suicide attempters do not keep their initial counselling/therapy

appointment and treatment 'drop-out' rates of 70 to 80% are not uncommon. Trautman, Stewart and Morishima (1993) reported that suicide attempters keep fewer appointments at a psychiatric outpatient clinic, and dropped out of treatment faster than other outpatients, although 77% of both groups dropped out of treatment before discharge. Females missed more appointments than males. The authors suggested several possible reasons for this: suicide attempters were not usually self-referred for psychiatric care, instead arriving at the clinic seeking medical assistance and were subsequently referred for psychiatric treatment by clinic staff; they were less (psychiatrically) ill than non-attempters; the individuals concerned and their families were less motivated to complete treatment. Dahlsgaard, Beck and Brown (1998) suggested that premature termination of therapy in adults with mood disorders resulted in higher levels of hopelessness and higher rates of eventual suicide, while Spirito and colleagues suggested that adolescents who drop out of treatment are at increased risk of re-attempt or completed suicide. It may be that those who discontinue treatment are at greater risk of repetition regardless of treatment; for example, perhaps there are factors that contribute to both increased suicide risk and non-compliance such as less supportive family relationships.

As discussed above, Crockwell and Burford (1995) reported on the importance of respect and mutual trust in therapeutic relationships, and the need for therapists and counsellors to consider the lived experiences of the individual. Discussion of 'non-compliance' tend to have a patronising air, suggesting an 'expert' stance which is incongruent with the issues raised by Crockwell and Burford's participants. To some extent, this is reflected in Trautman, Stewart and Morishima's (1993) observation that the patients concerned did not usually self-refer, indicating a lack of participation in the decision to seek treatment and a possible consequent lack of partnership in the relationship.

Stigma

One of the possible effects of being labelled as mentally ill is the risk of stigma. Sociologist Erving Goffman (1963) has been credited as making stigma a topic for social science research. In recent years stigma has come to be a central concern in the area of mental health. Stigma in itself may cause stress, through the discriminatory behaviour of others as well as the erosion of self-esteem and self-

efficacy. Stigma may also act as a barrier to recovery. In a New Zealand study of recovery from mental health problems, Lapsley and colleagues (2002) identified the attitudes and behaviour of others as the most common hindrance to recovery: people's lack of understanding, fears, stigmatising, and rejecting behaviour. Kirk (1992) and Link (2001) suggested that people who are aware of the potentially stigmatising labels that can be permanently attached to their medical records may be reluctant to seek services from mental health professionals, even if they have not personally experienced discrimination. People develop negative schema of mental illness early in life as part of socialisation; when an individual suspects he or she has developed a mental illness the possibility of discrimination and devaluation by others becomes a real fear. Schneider (in press) suggested that mentally ill people have the same stigmatising attitudes and stereotypes toward the mentally ill as others, and Link and Phelan went on to suggest that individuals who have been labelled as mentally ill may distance themselves by avoiding treatment. Lapsley and colleagues (2002) found that many participants were ashamed of becoming mentally unwell, resulting in lowered self-esteem, reluctance to seek help and impeded recovery. This may go some way to explain problems with non-compliance with treatment.

Repetition

Brittlebank, Cole, Hassanyeh, Kenny, Simpson and Scott (1990) found in their American study that approximately 20% of individuals who present for medical attention following a suicide attempt²⁰ repeat the attempt within 12 months, and Bennett and colleagues (2001) found that those repeatedly admitted to an Auckland hospital were more likely to be female. There is comparatively little literature which discusses repeat behaviours, or compares individuals who repeat the behaviour, particularly young people, with those for whom it is a 'one-off', and the findings of the studies I have been able to access are quite different. Johnsson Fridell, Öjehagen and Träskman-Bendz (1996) performed a follow-up study of Norwegian individuals admitted to hospital for suicide attempts. They found that the individuals who repeated their attempt rated their social network as less satisfying than those who did not repeat, both at the time of the original attempt, and at subsequent attempts.

²⁰ Brittlebank and colleagues refer to 'deliberate self-harm' but it is apparent from reading the article that the behaviours they are discussing are suicide attempts.

Other predictors for repetition include young age, and treatment of psychiatric disorder in parents. Vajda and Steinbeck (2000) reported quite different findings: Australian adolescents in their study who made repeated suicide attempts within 12 months were more likely to abuse substances, have a non-affective psychotic disorder (such as schizophrenia), have a chronic medical condition, or a history of sexual abuse. Brittlebank and colleagues found that repeaters score higher than non-repeaters on scores of hopelessness and hostility. However, the applicability of their findings to the current study is limited; the sample comprised both men and women (61% women) and the ages ranged from 16 to 67. Additionally, the study (as with many on this topic) only involved individuals who presented to a hospital, both initially, and when repeating suicidal behaviour. The differences in these findings may possibly be explained by differing methods and focuses on different factors.

Kerkhof and Nathawat (1989) argued that once people have attempted suicide, they would be more inclined to see it as a feasible option. There is some suggestion that the attention received following an incident of self-injury (whether self-mutilation or suicide attempt) becomes reinforcing, resulting in further incidents (Favazza, 1996). While presentation for treatment of a suicide attempt clearly provides an opportunity for intervention, exactly what that intervention should consist of remains unclear, particularly taking into account the somewhat contradictory views presented by Favazza – that attention can be reinforcing – and Crockwell and Burford – that interventions should be based on a partnership between the individual and the professional – located in the prevailing medical model.

Summary

In comparison to the literature available on risk factors and precursors to suicidal behaviour, material on cessation and recovery is limited. Although a number of intervention strategies and therapies have been employed, there does not appear to be a clear analysis of outcomes or coherent recommendations for treatment. The research that has been done suggests that addressing low self-esteem, a lack of social support, coping and problem-solving skills deficits and stigma may prove beneficial.

Prevention

As Fergusson and Lynskey (1995) noted, it is highly unlikely that accurate predictions of suicide risk within the general population will ever be possible. Therefore, the best approach to prevention of youth suicidality is not through attempts to predict who will become suicidal, but through improved prevention and intervention at all levels.

Resilience/Hardiness

Research suggested that the promotion of protective factors may offer an effective approach to both primary and secondary prevention of youth suicidal behaviour (for example, Wagman Borowsky, Ireland and Resnick (2001). Studies of resilience in general suggested a number of protective factors, such as self-esteem and self-efficacy, secure early attachments, availability of external support systems (Rutter, 1987), connection to parents or other significant adults and perhaps a greater sense of purpose (Debold et al., 1999). A study of over 36 000 American 12 to 18 year olds conducted by Resnick, Harris and Blum (1993) demonstrated the protective function of caring and connectedness, particularly connectedness to family and school. Low family stress and a sense of spirituality also functioned as protective factors, surpassing demographic variables such as family structure. Recognition of the complex interactions between factors has developed over time and the approach of building resilience focuses on strengths, resources and assets rather than pathology (Resnick, 2000).

Reporting on findings from a longitudinal study in Christchurch, Fergusson and Lynskey (1996) suggested that resilient teenagers are characterised by a significantly higher IQ, lower affiliations with delinquent peers and lower novelty-seeking. These factors act cumulatively. High self-esteem, interest in sports, school enjoyment, parental bonding and peer attachment were also identified as protective factors. However, American researchers Debold and colleagues (1999) suggested that girls' struggles are embedded in systemic problems such as racism, sexism and poverty; these issues require a collective response. Resilience, they argued, is too individually-based to describe the complex interactions that are the sources of adolescent girls' struggles. Resilience takes the individual out of context, ignoring the external oppressive forces that influence their lives.

The concept of hardiness, as used in health psychology, describes the position of an individual in relation to a stressful context (Sarafino, 2002). Hardiness consists of three components: control, commitment and challenge, and Debold and colleagues (1999) argued that using this framework it is possible to identify developmental experiences that may assist girls to combat the potential for harm inherent in racism and sexism. Control refers to the ability to understand stresses and analyse them in context and use positive coping strategies to make choices. Commitment describes the individual's sense of purpose, connection to others and recognition of available support systems. Challenge refers to the degree by which the individual feels challenged and motivated rather than defeated. In sum, hardiness describes knowing where to go for support, being able to utilise support effectively, and to be flexible and persistent. Debold and colleagues argue that the girls' stress and distress can be understood as a struggle to create an identity and belief system to which they can commit in the face of a loss of control in many areas in their lives. For girls to resist the stresses that may lead to risks and limited life choices they need experiences in which they can exert control over more than their bodies, appearance and sexuality. Debold and colleagues argue that young women need to have people they can connect with who will affirm their worth as well as providing encouragement and support.

Suicide Prevention Programmes

As with interventions, the literature on effective prevention strategies for suicidal behaviour is limited. However, there are some specific programmes that have been evaluated, and findings from these are discussed below.

Based on an evaluation of American school-based prevention programmes, Zenere and Lazarus (1997) recommended training school staff and parents in recognising warning signs of suicidal behaviour; putting crisis management plans in place in schools, including information on warning signs, suicidal contagion and assessment tools for evaluating risk; implementation of comprehensive suicide prevention programmes that begin at primary school; focusing on problem-solving skills, positive coping behaviours and self-esteem enhancement; procedures for evaluating suicide prevention and intervention efforts. However, as Gould and Kramer (2001) pointed out, evaluation of programmes is made difficult because of the relatively low

rate of suicidal behaviour, and the difficulty in gathering accurate statistics. Gould and Kramer suggested that females respond more positively to prevention efforts and are more likely to seek help than males.

Gould and colleagues (1998) also provided a meta-analysis of a number of American prevention strategies, such as school-based suicide awareness programmes, skills training, and screening for suicidality. The most effective appears to be provision of crisis centres and hotlines, which resulted in a decline of 35% of suicides in young White females. The potential of screening programmes is considered to be considerable if appropriate follow-up is provided, but a high rate of false positives has been identified as a key problem. School-based education appears to have limited efficacy. Skills training appears to be promising, but more research is required.

Discussing programmes to promote child and family wellness generally, Prilleltensky and Nelson (2000) noted the emphasis on individualist values and individual or family ecology approaches. Prilleltensky and Nelson argued that a greater emphasis on social interventions is needed. This, of necessity, incorporates a model of social responsibility rather than individual responsibility, in order to address social and economic determinants of maltreatment and wellness, in turn formulating solutions in terms of parental, communal and governmental responsibility. This approach echoes Debold's (1999) concern's regarding the individual nature of resilience factors. Given the acknowledged importance of the inter-relationship of individual and social factors, this perspective appears valuable.

New Zealand Youth Suicide Prevention Strategy

In New Zealand the focus on youth suicide prevention has increased markedly in the last decade. Key players in this development have been the Ministries of Health and Youth Affairs, through the formulation of the New Zealand Youth Suicide Prevention Strategy in 1998. This has involved the production of a number of documents (Beautrais, 1998a, 1998b; Lawson-Te Aho, 1998a, 1998b) and the formulation of a framework for prevention consisting of five goals:

- Promoting well-being
- Early identification and help

- Crisis support and treatment
- Support after a suicide
- Information and research

Suicide Prevention Information New Zealand (SPINZ) is a key organisation in the fifth goal, pooling the resources of several organisations to provided a website and resources such as community information kits. It is funded by the Ministry of Youth Affairs.

The Ministries of Youth Affairs, Education and Health are continuing to promote and fund a range of initiatives in line with the prevention strategy. While the prevention strategy appears promising, at this time the effect of these initiatives is yet to be determined.

Conclusion

In conclusion, suicidal behaviour arises from a multitude of factors that males and females react to differently in accordance with their personal histories and pathology combined with values based on gender stereotypes and other psychosocial factors. Many of the risk factors are inter-related, such as unemployment, poverty, abuse, and depression. Although examining single aspects of suicidal behaviour in isolation is more manageable, it appears that the whole person and their environment needs to be considered, whether we are examining risk factors, intervention, or prevention strategies. This theory is supported by van Heeringen and colleagues (2000):

Recent findings from... apparently divergent areas such as ethology, psychology, biology and sociology tend to converge to such an extent that...questions like whether suicidal behaviour is primarily a psychologically defined problem or...due to biological characteristics, no longer appear relevant (p. 223).

This literature review suggests that although the majority of young women who engage in suicidal behaviour may be diagnosable with clinical depression, and some are diagnosable with another disorder such as Borderline Personality Disorder or

Post-Traumatic Stress Disorder, the impact of social factors underlying these 'disorders' is also important. A history of sexual abuse may be found in many of these women, and family difficulties are also expected. In addition, some women may also have been involved in other self-harming behaviour, such as eating disorders or self-mutilation.

Statistics suggest that the majority of young women who self-injure do not go on to commit suicide. Yet the rate of hospitalisation for this type of behaviour drops markedly between ages 20 and 25; from near 300 females per 100, 000 population to less than 200, with a further drop by age 30. As Kushner (1995) noted, the portrayal of suicidal behaviour as a male preserve may tell us more about the assumptions of statistics collectors than it does about suicidal behaviour. If we really wish to understand suicidal behaviour, instead of asking "why do young men kill themselves?", perhaps we should ask "why do young people wish to harm themselves?" and "Why, and how, do they stop?".

CHAPTER THREE: METHODS

The previous two chapters introduced the topic of suicidal behaviour generally, and established the reasons for focusing on a particular sub-set: non-fatal suicidal behaviour in young women. This chapter discussed the sample, examines the theoretical underpinnings of methods chosen for the conduct of the research and the rationale for these choices, and describes the method and participants. The methodology discussion also includes a brief statement of the experiences and values the researcher brings to the research. Finally, the chapter provided details of the ethical review procedures undertaken, and outlines the supervision arrangements.

Both the sample and the data collection for this thesis have consisted of two distinct components, as described in detail below. This method has been adopted in order to gain as large a sample as possible so that the research is representative; to compare and contrast the perspectives of a variety of people involved in the phenomenon of deliberate self-injury; and to ensure that a variety of voices engaged in this contentious and little-understood phenomenon are heard, in order to represent the population of interest as accurately as possible.

Component One data were gathered through interviews with key informants. Due to concerns about the risk of causing distress to young people who engage in deliberate self-injury, after consultation with the chief supervisor, it was decided that the initial stage of the research would be conducted through key informants who work with at-risk youth. This has had the added benefit of facilitating a greater understanding of the context of the behaviour, to ascertain current procedures and protocols. These key informants were recruited through the networks of the researcher.

Component Two of this research comprised interviews with women who had engaged in suicidal behaviour while aged under 25. It sought to include participants with a range of experiences of medical and mental health services in relation to suicidal behaviour, including no experience of services at all. This decision was made so that experiences of recovery and cessation could be compared and contrasted, as well as providing a more realistic picture of the population's experiences. This was

achieved by recruiting participants using a variety of methods, rather than, for example, recruiting solely from counselling and mental health services.

Methodology

The vast majority of research into suicidal behaviour, both in New Zealand and internationally, uses quantitative methods and is informed by the medical model. Mook, Wertz and van Zuuren (1986) argued that in its quest for scientific status psychology adopted the methods of the natural sciences. Quantitative methods applied to the social sciences may require that, for example, interviews always be conducted in the same way, with the researchers distancing themselves from the 'subject' and avoiding subjective interpretations in order to obtain objective 'true' results. As explained by Rice and Ezzy (1999), positivists prefer quantitative methods, avoiding interpretivist explanations that refer to human intentions and emotions. Rice and Ezzy suggested that this positivistic quantitative approach is of limited applicability to the study of human behaviour; in order to understand people you must understand their interpretations of actions and events. Miller and Fredericks (1994) went so far as to claim that logical positivism is 'dead'. Furthermore, the notion of 'truth' is problematic in itself (Miller and Fredericks, 1994; Tolich & Davidson, 1999), particularly when applied to interpretations of human behaviour and perceptions. When behaviour is transformed into the abstract, what is examined are social science problems, the concerns and issues of our experiences, not social problems, argued feminist researchers (Stanley & Wise, 1983). In contrast, this thesis uses qualitative methods of research and analyses.

From the qualitative viewpoint, reality is socially constructed. The attempt to understand meanings and interpretations is a guiding principle of qualitative research; it seeks insight into the meaning of the subject rather than the stock-taking of relevant facts. This illumination of meaning involves interpretive thinking and consideration of data contextually. The qualitative paradigm asserts that no issue can be understood in isolation from its environment (Tolich & Davidson, 1999). In contrast to the quantitative approach, the qualitative approach sees variables as complex, interwoven and difficult to measure. As a result, not every aspect of qualitative research can be accomplished by following a set of rules or formulae (Wertz & van Zuuren, 1986).

Although the methods used in this thesis are qualitative, an eclectic mix of methodologies informed the overall research structure. Chief among these are phenomenological and narrative approaches and grounded theory. Rice and Ezzy (1999, citing Heidegger, 1962) argued that to separate person and world is an absurdity; to be a person is to be in a world, a person's experiences are formed in shared social practices. It is phenomenological concepts such as this that underpin this thesis.

Phenomenologists argued that individuals' actions can only be understood in the context of their everyday world; actions are rooted in interpretations and reactions. A focus of this model is establishing meaning from the point of view of the participants in a social environment (Baker, 1999). As Sartre (1962, p.29) put it: "psychology should endeavour not so much to collect the facts as to interrogate the *phenomena* – that is, the actual psychic events". The founder of phenomenology was Husserl, who described the philosophy of phenomenology as a science of experience (Wertz & van Zuuren, 1986).

The narrative approach to research allows for the individual's "story" to be told, replete with contextual information and rich in interpretations. To return to Heidegger: "human beings do not understand themselves as detached human beings, but through engaged activities" (cited by Rice & Ezzy, 1999, p. 121). The narrative approach is particularly apt for this thesis in that it seeks to understand social impacts on behaviour; these social impacts are, by definition, embedded in women's experiences and interactions. The narrative is the tool by which we describe our history and our present and make sense of our experiences; it is the means by which links between the body, self and society are articulated. The study of narratives has the potential to reveal wider issues to do with links between identity, experience and culture (Bury, 2001).

Grounded theory is a reflective, inductive approach to data gathering and analysis, and is associated with the work of Strauss, Glaser and Corbin during the 1990s. This dynamic research method involves moving from data collection to generating insights and theoretical concepts then back to data collection to verify those concepts and to continue to inform the data collection process; it is an ongoing comparing of incoming data. Theory is both built and tested at the same time (Hoenkamp-

Bisschops, 1986). This circular process results in theories that are 'grounded' in the data (Baker, 1999; Rice & Ezzy, 1999).

In the reflexive process of engaging with the participants and encouraging them to give voice to their experiences, it becomes impossible to stand apart from the research as an objective, value-free, neutral observer. The researcher's own values and experiences can not be fully separated from the choice of theoretical standpoint, or interpretations of participants' stories (Baker, 1999). With this in mind, it is appropriate to make explicit the history and attitudes I have brought to this thesis.

The town I grew up in during the late 1960s through to the early 1980s, was rumoured to have the highest crime and suicide rates in the country, at that time. Whether that is true I do not know; I do know that as a working-class teenager in a 'troubled' family, the 'seedier' side of life directly or indirectly touched my life and that of most of my friends, including suicide and the mundane crimes of theft, domestic violence and rape. These aspects of life, particularly suicidal behaviour and other forms of self-harm, were rarely discussed. While violence and crime generally were accepted as, if not normal, then unavoidable and therefore best ignored until they could be joked about, self-harm was one of only two taboo topics that I can recall, the other being child sexual abuse. On the rare occasion that they were discussed it was with a pervading sense of shame for all concerned. Yet my reality is that my life and the lives of many of my peers were touched by the risk factors involved in suicidal behaviour, and by suicidal behaviour itself. These were the days before youth workers; when the school guidance counsellors were the people you were sent to see if your behaviour was bad or you wanted career advice; seeing a psychologist was simply unheard of. It is this intertwining of the risk factors for suicidal behaviour with silence about its existence that brings me to this point: the knowledge that as young women some of us found ourselves in dire straits; the differences were infrequently discussed and rarely analysed. We sank, or swam, or alternated both, largely in silence.

My own experiences eventually influenced my career path and I became involved with community organisations as a youth worker and as a community worker for a women's wellness organisation. Through these experiences I continued to develop an awareness of the social complexity that underlie young women's decisions. My

interest in these issues was piqued by the realisation that I, as an individual, could offer little to young women (as individuals or as a group) if the background social environment remained the same. It was this realisation of the meshing of the ecology with the individual that brought me to my current studies of community psychology, with its focus on social justice, self-determination, empowerment and recognition of human diversity.

My internalisation of these values has shaped my approach to this research. As with all researchers, I hope to add to the body of knowledge on the topic. It has also been my intention to do this in a way that recognises the expertise of the participants, to have them truly “participate”. I also hope that, for the women who spoke of their personal experiences of suicidal behaviour and its underlying factors, that the experience has been freeing, perhaps, for some, even empowering. My intention for this thesis is to go beyond stating, “If x happens to y, then z”, to determine the answers to questions such as “Who is y – the person? What did x and z mean to her?”.

How is it that some young women come to feel that their only option is death? Most of them do not die; what happens to them next? What do they have to tell us about their experiences? What can we learn from them? These are the fundamental questions that lie beneath this thesis; questions that stories of women’s lived experiences can answer, and that only a broad focus can adequately address. The most important goal – the ‘what’ - of this research is to explore the social aspects of suicidal behaviour on young women, particularly in relation to recovery and prevention. Allowing the women concerned to give voice to their experiences in a way that values their knowledge is the ‘how’. This way of framing the research is borne of my desire to acknowledge that the participants are the experts: they know why they made the choices they did and how their choices and the choices of others impacted upon them. This thesis attempts to present their voices.

Sample Size

When qualitative research methods are used, sample size is determined by theoretical, not statistical, reasoning. Strauss and Corbin (1990) argued that the sample size is appropriate when ‘theoretical saturation’ is reached; that is, when no new relevant data is obtained from participants, and the key elements of the study are established

and validated. Clearly, a suitable sample size cannot be determined prior to research commencing; rather, the decision is an outcome of reflection on the research process and concurrent evaluation of the information gathered. As Rice and Ezzy (1999) put it, qualitative data gathering aims to create rich, in-depth information; data collection should be terminated when no new information is forthcoming; thus, redundancy is the primary criterion. “The number of participants is less important than the richness of the data” (p. 47).

Data Analysis

For both components of the research, analysis has been conducted in tandem with data collection to inform the next interview, in accordance with the grounded theory approach. On receiving confirmation from informants and participants of the accuracy of all the data gathered, the data was analysed thematically using the QSR Nud*ist software package for qualitative analysis. An initial node tree was set up using the most salient issues arising from the first three interviews and through text searches for particular words and phrases identified from the literature review. These nodes were grouped into risk factors, cessation, and intervention and prevention strategies. Further nodes were added as data collection progressed. In addition, in accordance with narrative analysis, interview tape-recordings were considered in their entirety, in order to ensure that the context and inter-relationships of participants’ experiences was included in the research findings.

Methods

Component One

In this component data were gathered through interviews with key informants: people working with women who have made suicide attempts such as counsellors, school guidance counsellors, youth workers and researchers in the field. Key informants were recruited using a snowball technique; descriptions of their positions are given below. A key purpose of these initial discussions was to gain a greater understanding of the context of the behaviour and to ascertain current procedures and protocols. Key informant interviews were guided by a series of open-ended questions and prompts. These included:

- What are the usual demographics of clients who have engaged in deliberate self-injury?

- What would you consider to be the primary factors that may contribute to deliberate self-injury?
- What would you consider to be primary factors that contribute to the cessation and recovery from self-injurious behaviour?
- What is your organisation's current policy for dealing with people who self-injure (e.g. if participant is a hospital social worker, are all people who are treated for suicide attempts/deliberate self-injury automatically referred to counselling services? What is the usual duration of counselling?)

The findings from these interviews were collated and used to inform the subsequent stages of the research.

Participants

Participants in Component One of the research were key informants from the Christchurch, Hamilton and Auckland regions. Beginning with people I knew, participants were recruited using a 'snowball' sampling technique and were approached because of their experience in dealing with suicidal youth. I initially contacted participants by telephone, and the research was discussed. If the participant expressed an interest in the research they were sent an information sheet (see Appendix One). After allowing potential participants time to consider their involvement they were telephoned again to make an interview appointment, if they were agreeable.

Participants consisted of members of the following types of organisations: two school guidance counsellors; seven private counsellors or therapists; four youth health service workers employed by Government departments; one education service worker employed by a Government department; one community (non-Governmental) education service worker; one researcher employed by a Government department; and 8 (non-Governmental) community workers. A total of 25 key informants were interviewed, from 15 organisations.

The participants were based in south Auckland/Manukau, Auckland city centre, Christchurch and Hamilton. One of the Hamilton participants also worked in smaller towns in the Waikato area and 2 of the Christchurch participants travelled

within the Canterbury region. Table 1 provides a demographical breakdown of participants.

	Male	Female	Total	Province:	
Pakeha	1	14	15	Greater Auckland	8
Maori	4	6	10	Waikato	13
Other	0	0	0	Canterbury	4

Table 1: Component One informants’ ethnicity, gender and the geographical location of their work-sites.

The ethnic make-up of participants’ clients varied widely, but tended to reflect the population of their geographical location. For example, participants working in the south Auckland and Manukau areas reported roughly even numbers of Maori, Pakeha and Pacific Island clients, with a few other ethnicities such as Indian, while the participant working in the Auckland city centre had few Maori clients, and a higher proportion of Asians. In contrast, Christchurch participants dealt largely with Pakeha. Two of the eight Hamilton agencies specifically targeted young Maori; these two agencies provided five participants. Of the remaining eight Hamilton participants, 6 reported dealing with similar numbers of Maori, Pakeha and a group classified as ‘others’. One of the two other participants, school guidance counsellors, saw predominantly Pakeha youth. The remaining participants’ clients were mainly Maori; this participant also worked in small towns with low socio-economic status in the Waikato area, which typically have a high Maori population.

Procedure

This part of the research consisted of interviews with the key informants described above. Interviews were semi-structured in nature, at venues agreed upon by the informants and researcher. In all cases except two, interviews were conducted at the participants’ place of work. In one case the interview was conducted in the informant’s home, while in another the interview was conducted by telephone. In total, 15 interviews took place, and in four cases (where several members of the same organisation were to be interviewed), group interviews were held.

Interviews were audio-taped (with the informants' permission), supplemented by hand-written notes. Notes of the interviews were typed up and returned to informants, who were asked to ensure that they were an accurate representation of their opinions. Addressed, post-paid envelopes were provided to facilitate the return of comments and corrections. Informants were advised that if a response was not received within one month of the notes being sent to them, it would be assumed that they had nothing further to add. Four informants provided further comments.

In addition, two of the organisations (one in south Auckland, the other in Hamilton) volunteered statistical demographic information on their clients; this information was not readily available from the other organisations.

Thematic data analysis was performed using the QSR Nud*ist computer software package.

Component Two

As discussed in the preceding chapters, the population of interest in this thesis is women who engaged in non-fatal suicidal behaviour while aged under 25. In the second component of the research women who had previously engaged in suicidal behaviour (as defined in Chapter One) were recruited. Suicidal behaviour may be viewed as an indicator of more general social dysfunction, rather than psychopathology alone (Berman & Cohen-Sandler, 1982; Langford, Ritchie & Ritchie, 1998; van Heeringen, Hawton & Williams, 2000). In addition, as noted by Gould and colleagues (1998), clinical samples demonstrate higher rates of co-morbidity than community samples, leading to an increased risk of sample bias. Due to this potential bias, and because a large number of young female self-injurers do

Prevention Research Unit and the University of Waikato Community Psychology programme and through sending letters and information sheets to relevant community organisations in Auckland, Hamilton and Christchurch. A copy of the information sheet is attached as Appendix Two.

Participants made contact with the researcher in a variety of ways: by letter, by telephone, and by email. All potential participants were provided with an information sheet and asked to contact the researcher again after reading the information, if they wished to take part. At the time of this second contact, in the interests of ensuring the safety of participants, it was stressed to all potential participants that at least one year must have elapsed since their last episode of suicidal behaviour, and that they should feel that they had 'recovered'; they should also consider whether they felt comfortable with discussing their experiences with the researcher. Participants were also asked if they had a counsellor or therapist available, should they wish to speak with some one after the interview, and advised that if they did not, one would be arranged for them. They were also told that they could refuse to answer any questions and that they could withdraw from the research at any time. Four women who initially made contact chose not to take part in the research; in three cases the reasons are unknown as no further contact was made. In the fourth case the potential participant found out she was pregnant while she was considering involvement and decided against possibly exposing herself to additional stress at that time.

Participants

A total of 24 women took part in the second component of the research. The following tables provided the participants' geographical location, ethnicity and age at the time of the interview.

	Provincial Town	City ²¹	Total
Pakeha	3	18	21
Maori		2	2
Other		1	1

Table 2: Component Two participants’ ethnicity and geographical setting at the time of the interview.

Province:	
Auckland	7
Waikato	6
Canterbury	4
Otago	2
Bay of Plenty/Coromandel	1
Wellington/Wairarapa	1
Nelson/Marlborough	1
Undisclosed	1

Table 3: Component Two participants’ geographical location at the time of the interview.

	20 – 24	25 – 29	30 – 34	35+ ²²
Pakeha	5	5	5	5
Maori	2			
Other			1	

Table 4: Component Two participants’ age at time of interview.

The youngest participant was aged 21 at the time of the interview, while the oldest was 46. The average age was 29.6 years. Although two had engaged in low-lethality

²¹ Denoteds the geographical location in which the participant lived at the time of the interview

²² Denoteds age at time of interview.

self-mutilation within the previous year, most commonly cutting, none had made a suicide attempt in the past year. The amount of elapsed time between the last suicide attempt and the interview ranged from 15 months to 30 years. In 10 cases it was within the previous five years, with the average lapse of time being 9.8 years.

Most (23) of the participants spent their childhood living with at least one biological parent, with the remaining participant having been adopted. However, only 11 participants reported that their biological parents were cohabiting at the time of the participant's first suicide attempt. In eight cases the parents separated at some point of the participant's childhood or adolescence; in three cases one parent had died, and in one case both parents had died. Of this total of five deceased parents, one is known to have committed suicide, and another is thought to have committed suicide. Three participants lived in boarding schools for much of their adolescence – one of these participants was sent to boarding school after the death of both her parents.

Although a range of methods were used in order to recruit a diverse range of participants, only two of the 24 component two participants were Maori. At the time that this research was initially being considered, the available statistics suggested that Maori females had higher rates of self-injury than non-Maori. With this in mind, it was hoped that this thesis might provided valuable insights into this phenomenon. However, after consultation with Maori researchers it was decided that it would not be appropriate for a Pakeha researcher to specifically seek out Maori participants, and if Maori volunteered to participate a Maori interviewer would be offered. This option was mentioned on the participant information sheet (Appendix Two). None of the participants mentioned their ethnicity prior to the interviews, and neither of the Maori participants requested a Maori interviewer.

Procedure

The open-ended, semi-structured method of interviewing was chosen in recognition that to attempt to fit the participants' varied experiences into a 'one size suits all' structure would risk losing the subtleties of their interpretations. It facilitates access to information the researcher could not have considered (Burns, 1994). In line with the narrative approach, once the preliminaries to the interview had been conducted (discussion about consent, recording of the interview, making the participant

comfortable, discussion of the topic and so forth), the participants were encouraged to tell their 'story', beginning with the background to becoming suicidal. During this stage my role was solely one of encouraging the process of story-telling. The second stage was one of seeking clarification and elaboration, referring to the prompts listed in the interview guide (Appendix Four).

Participants were given the choice of communication. Eighteen chose to be interviewed in person, three interviews were conducted solely by email, two by a combination of email and telephone, and, in one case, by letter²³. All of those interviews carried out in person were conducted at venues agreed upon by the participant and the researcher. Venues included the participant's home in six cases, the home of a friend or relative in two cases, an office at the University of Waikato in five cases, an office at the University of Auckland in two cases, the researcher's home in one case and at the work-place of the participant in one case.

Before each interview, participants were given the opportunity to ask questions. They were also reminded of their right to withdraw from the research at any time, and to refuse to answer questions. In the case of the interviews conducted in person, participants were asked if the interview could be tape-recorded, and advised that a copy of the interview notes would be returned to them for comment and correction. Although participants were given the option of having a support person with them at the interview, this occurred in only two cases. Participants were assured that names and identifying information would not be used in the thesis, and that every effort would be made to preserve anonymity at every stage of the research process. Participants were then asked to sign a consent form, except in the case of interviews conducted by email; in these cases the preliminary email 'conversations' in which initial contact was made by the participant and participation was negotiated were printed and kept as a verification of consent.

²³ While all methods of gathering information were adequate, those conducted by email and letter were considerably more time-consuming. Those conducted in person produced a relatively richer narrative.

Interviews conducted in person lasted an average of 1½ hours. The shortest interview was over in approximately one hour, while the longest took 3 hours. All these interviews were audio-taped, with the permission of the participant. In the majority of cases, few questions were asked; as discussed above, the interviewer allowed the participant to talk about their experiences in a narrative style, followed by the interviewer summing up the narrative and seeking clarification as appropriate. If any areas of interest had not been discussed at this point, the interviewer used the prompts given in Appendix Four.

In the case of interviews conducted by email and phone, participants were emailed the interview guidelines to reflect on and respond to, as they felt appropriate. Clarification and discussion of some points followed, usually by telephone, but in one case the total data collection process was by email, the participant's preference.

As with Component One, copies of the interview notes were given to participants to check their accuracy. Participants were also invited to comment on and critique the interview process itself, as a form of informal evaluation, to potentially benefit future participants. Approximately half made comments, largely to the effect that they had enjoyed or appreciated the process; in some cases it was the first time they had talked about their suicidal behaviour in any detail, and several remarked that it was interesting to see how their lives and perspectives had changed: "I felt like I was reading about some-one else!".

As with Component One, thematic data analysis was performed utilising the QSR Nud*ist software package.

Ethical Statement

The code of ethics of the New Zealand Psychological Society (1986) was used as a framework for designing the research. The proposed research was then subject to an ethical review carried out by the Research Committee of the Psychology Department, University of Waikato.

Due to a commitment to conducting research that is culturally safe and appropriate for all participants, and is aligned with Pakeha obligations under the Treaty of Waitangi, efforts have been made to ensure protection, participation and partnership

with Maori at all stages of the research. The research has been designed in consultation with the staff of the Maori and Psychology Research Unit (MPRU), and consultation with Maori has been on-going. As discussed above, some statistics suggested that a large proportion of the population concerned is Maori; this further strengthens the need for culturally appropriate practice. Research questions and procedures were developed in consultation with the Maori in Psychology Research Unit, and other Maori researchers, including a member of the Department's clinical staff. Efforts have been made to ensure that a number of participants were Maori, particularly in Component One. However, due to the sensitive nature of the topic, and my own ethnicity (Pakeha), it was decided that it would be inappropriate for the second stage of the research to focus on specific Maori experiences. If participants saw their ethnicity as an important factor in their experiences, they were encouraged to discuss this; however, questions specifically related to ethnicity were not asked. In addition, as discussed above, participants were invited to bring a support person and they were given the option of a Maori interviewer.

Right to withdraw

Participants were informed of their right to withdraw from the research at any time, both by way of an information sheet sent to participants before interviews took place and verbally at the beginning of the interview (see Appendices One and Two).

Supervision

Staff of the Psychology Department, University of Waikato, provided supervision: Professor Jane Ritchie, Dr Michael Hills and Dr Neville Robertson. The Department's Maori and Psychology Research Unit and a member of the Clinical Programme Staff, Dr Averil Herbert, provided additional guidance.

CHAPTER FOUR: COMPONENT ONE FINDINGS

Component One data was gathered through interviews with key informants. Due to concerns about the risk of causing distress to young people who engage in suicidal behaviour, after consultation with the chief supervisor, it was decided that the initial stage of the research would be conducted through key informants who work with at-risk youth. This has had the added benefit of facilitating a greater understanding of the context of the behaviour, to inform the second stage of the research and to provide a comparison between Component One and Component Two informants' perspectives of suicidal behaviour. These key informants were recruited through the networks of the researcher. In total, 25 people participated, from 15 organisations.

This chapter presents the findings arising from discussions with the key informants. It begins with a brief description of the informants to provide the context for their observations; a more detailed description of the participant group has been provided in Chapter Three. The rest of the chapter reported on the findings, beginning with risk factors, followed by the warning signs that the informants had observed. The cessation of suicidal behaviour is then discussed, and the chapter ends with informants' perspectives on interventions.

Participant Descriptions

Of the 25 informants, six were male, and 19 were female. Fifteen were Pakeha or did not specify their ethnicity and 10 Maori; seven worked in the South Auckland or Manukau areas, one in the Auckland city centre, four in Christchurch and 13 worked in Hamilton. Two of the Christchurch informants and one of the Hamilton informants also worked in smaller towns in the region.

Nine informants were non-Governmental community workers, seven were private counsellors or therapists, four were youth health service workers employed by Government departments, two were school guidance counsellors, two were education service workers and one was a researcher employed by the health service.

The ethnic make-up of informants' clients varied widely, but tended to reflect the general population of their geographical location.

Risk Factors

This section of the chapter presents the observations of the informants in regards to background factors for suicidal behaviour. It begins by discussing psychopathology and then moves on to social factors. Informants identified a range of cultural factors, including youth culture, gendered culture and ethnicity. In addition to being risk factors, some of these factors also influence means of suicidal behaviour, help-seeking behaviours and informants' approach to treatment. Family factors follow, incorporating social class, abuse and neglect. The section ends with an exploration of interpersonal factors.

Informants working within the government health system (particularly those with a medical background) tended to describe risk factors primarily in terms of psychopathology, although also acknowledging the possible contribution of other factors. Informants working in community organisations identified life events or social circumstances. Some informants acknowledged that their clients were not typical of the population of interest; for example one counselling service has a reputation for specialising in sexual abuse, so the young women they see are probably more likely to have been sexually abused, while others targeted Maori youth.

The most common risk factors that informants identified are as follows.

Psychopathology

Most informants stated that a mood disorder was present in almost every case, and depression was clearly the most common diagnosis. According to informants, in some cases anxiety or attachment disorders were an issue, as were personality disorders, particularly Borderline Personality Disorder. Substance abuse, conduct disorders and eating disorders were also frequently seen alongside depression.

There was a clear divergence of informants' perspectives regarding the importance of psychopathology; as mentioned above, some of those working from a medical model appeared to focus on diagnosing and treating a pathology. Others, such as community-based workers, were more concerned with the wider context and factors

underlying the individuals' suicidal behaviour, or the reasons for their depression. 'Disorders' were mentioned very briefly, if at all by these informants.

Social Factors

The following section discusses the social factors informants identified as contributing to suicidal behaviour. The section begins with macrosocial factors such as culture, gender and ethnicity and moves on to interpersonal factors such as family and personal relationships.

Youth Culture

Although no informants suggested that there were aspects of youth culture that in themselves would put young people at risk of suicidal behaviour, informants identified a number of cultural influences, largely specific to young people, that may influence those already vulnerable. Two informants spoke about the manner in which young people's attitudes to suicide are constructed:

Although most of them [students at a high school who engaged in suicidal behaviour] didn't know each other it is part of a 'fashion' – socially constructed. There are waves of suicide talk that individuals may take on board. Teenagers don't have much of a positive history to define themselves by – they're young, they don't have life experience. Those that are vulnerable may take up the positions that are offered to them, whereas others would reject that way of being.

- Pakeha male school counsellor

One participant felt that some young women do not consider a suicide attempt to be 'a big deal', but almost a rite of passage, like smoking their first cigarette, or having sex for the first time.

The most common cultural aspect identified was music. For example:

A few years ago we had a run of suicide pacts. These were 'Goths'²⁴ who were heavily into destructive attitudes, music and behaviours, satanic rituals etcetera. They weren't the more common 'copy-cat' attempts, they were organized agreements. They were difficult to deal with, and it was a very dark time.

- Pakeha female community-based counsellor

Some lyrics are encouraging of death, especially when combined with drugs or alcohol. There is a lot of violence in music, especially rap and metal – it's full of aggression and violence, which is portrayed as 'cool'. There are sometimes groups of teenagers who see suicidal ideation as cool...if people are stable it has little effect...but if there's something underlying it feeds into it. It comes back to a loss of culture, and needing something to identify with – even if it's a Nike symbol. They've taken up an American culture which is anger-based.

- Maori female community-based counsellor

Gender

There were two key differences identified by informants in regards to suicidal behaviour among young men and young women, both relating to coping mechanisms. Firstly, informants noted that boys rarely feel that they have someone they can talk about personal problems and emotions with, whereas girls usually have close friends with whom they can talk about these issues. The result appears to be that young men tend to progress from depression to suicidal ideation to suicidal behaviour more quickly than most young women do. However, not all young women have these close friendships, and for those who do, the support or comfort attained may be insufficient for her to deal with the situation positively and effectively.

Girls seem to verbalise more, but boys don't have the skills. Boys sometimes say they wish they could 'yack away to mates like girls do'.

²⁴ 'Goths' typically listen to a variety of heavy metal music known as 'death metal', 'black metal' or 'Gothic', typified by singer Marilyn Manson. They are frequently recognisable by their heavy make-up – usually black lip-stick and eye-liner against a pallid background, black clothes, and facial piercings.

For girls, talking to friends can act as a release valve, but there is difficulty in communicating with family.

- Pakeha female community-based counsellor

Secondly, in the informants' opinions, young men's behaviour when stressed, depressed or anxious tends to be more noticeable; they are more likely to externalise their emotions, often presenting as angry. As a result they are more likely to get attention, albeit often negative, at least initially. In contrast young women are more likely to internalise their emotions, often becoming socially withdrawn, and perhaps resorting to self-harming or mutilating behaviour such as excessive dieting or cutting. It was the belief of most of the informants that these young women are at greatest risk of suicidal behaviour.

Conversely, some young women also engage in externalising behaviour, and these girls appear more likely to engage in risk-taking behaviour that, while potentially destructive, would not normally be considered actively suicidal. These behaviours include substance abuse, and endangering their personal safety through the company they keep, for example gang associates. Informants were divided as to the potential suicidality of these young women. Many felt that this 'acting out' appeared to provide a release of negative emotion, at least in the short-term, thereby avoiding serious suicidal behaviour. Alternatively, some informants felt that a significant number of this group go on to become actively suicidal, often going through a more classical depression phase encompassing the social withdrawal discussed above.

Informants felt that risk factors for young men and young women are largely the same, with two main differences; sexual abuse seems to be more likely to be a factor for young women, and schooling difficulties seem more likely to be a factor for young men.

"Girls tend to manage school remarkably well, even when they might have some major problems."

- Maori female community-based counsellor

Ethnicity

Informants' views on the importance of ethnicity as a risk factor were mixed, with three main perspectives:

One informant, a senior researcher in the field, said that the ethnic breakdown of her research participants was in accordance with the general population, and believed that ethnicity had no impact on suicidal behaviour. Her data was gained from people formally hospitalised; it may be that members of ethnic groups other than Pakeha are less likely to be hospitalised. As discussed in Chapter Two, data gathered from hospitalisations may not be representative of the population as a whole. Another informant, herself Maori and a community-based social worker, also did not consider that ethnicity had any particular influence on suicidal behaviour.

Conversely, many informants noted a disparity among ethnic groups in relation to the prevalence of suicidal behaviour; indeed, two participating community agencies were able to provide statistics that demonstrated disproportionately high numbers of Maori and Pacific Island clients, although they did not deliberately target any ethnic groups. These disparities could not be fully explained by the local population base and their clients were composed of a wide range of young women including those who had not received medical attention. The majority considered that this ethnicity-based disproportion was largely a factor of poverty. That is, although certain ethnic groups have higher rates of suicidal behaviour, this is attributable to increased poverty and its corollaries such as overcrowded living conditions, poor education and lack of access to social services.

At the same time, several informants from the informant group as a whole believed very strongly that culture in itself contributed to some individuals' suicidal behaviour, regardless of economic status. Rather, the long-term results of colonisation, such as institutional racism, are the chief underlying cause of high rates of suicidal behaviour. These informants argued that culture also affects help-seeking behaviour.

Informants' perceptions of specific ethnic groups follows.

Maori

Several informants considered that a higher rate of suicidal behaviour among Maori was due to Maori being more likely to be from underprivileged backgrounds:

Suicide attempts by young Maori are definitely disproportionately high when considered against the school's population. This may be linked to the higher likelihood of being in a one-parent family, and higher incidence of sexual abuse.

- Pakeha female school counsellor

Three informants, all Maori, also discussed Maori identity as a risk factor in itself. They all felt that this varied according to the individuals' connectedness to their marae and Maori culture, noting that this was often a result of their geographical location:

A lot of urban Maori are dissociated from their families, as opposed to rural Maori who are much more likely to have hapu support. There's a lot of poverty. Parents have a lot on their plate and the kids don't have anything to keep them occupied, so they get involved in risk-taking behaviour...Maori are taught they're lower – they don't feel they're part of the community.

- Maori male community worker

For Maori, lack of identity is an issue, they don't know who they are. They've lost the sense of who they are through colonisation, so they try other cultures such as America. There's a lack of direction and leadership, so they adopt US heroes.

- Maori female community-based counsellor

Pakeha participants also identified some stressors that were attributed to isolation from one's culture:

“Maori kids don't get heard [in this school], the environment is monocultural”

- Pakeha male school counsellor

The Maori kids we see are likely to be isolated from their families. None of my Maori clients have been [local iwi] – they’ve all been from out of town, so don’t have that wider circle.

- Pakeha female community-based counsellor

Informants also discussed possible protective factors of Maori culture:

It’s more than just the impact of being poor – there is also the issue of identity crisis. Cultural aspects may vary between urban and Maori based closer to the marae. [Those who] are distant from the marae are more susceptible. Being closely attached to the marae is a protecting factor. Some urban kids see going to the marae as meaningless, and if they do go back they feel embarrassed and inferior – they don’t know what’s going on.

- Maori male community-based counsellor

Maori often have more connection to whanau than Pakeha.

- Pakeha female community-based counsellor

Young Maori who go to kapa haka and similar cultural activities seem to be more ‘connected’ and less likely to harm themselves. That sense of connectedness, once made, seems to endure for years, possibly throughout their lives.

- Maori female community-based counsellor

Two informants made comparisons between Pakeha and Maori parenting styles, suggesting that these impact upon the likelihood of children being at risk. They suggested that Maori parents are more willing to let their children go without supervision, particularly when on the marae, and that this is when a lot of abuse occurs.

Maori and Pakeha girls [who engage in suicidal behaviour] have usually been sexually abused. Maori abusers tend to be within the wider whanau rather than their father.

- Pakeha female community-based counsellor

Pacific Island

All informants who worked with Pacific Islanders spoke of the difficulties these young women have in trying to fit into New Zealand culture, particularly if they were born in the Islands. The expectations and restrictions of their families and church are often in conflict with the Palagi culture, which represents greater freedom.

The mothers of Pacific Island girls seem to have higher domestic expectations, which is difficult for girls trying to assimilate into the Palagi world.

- Pakeha female community-based counsellor

Pacific Island girls are very embarrassed to be praised, or to stand out in anyway – they talk about shame more and evaluate themselves as ‘nobody’...there is a lot of pressure on girls to remain virgins until their wedding night...yet we’ve seen a number of these girls that have been sexually abused by their fathers. Obviously this creates an additional burden of shame and desperation.

- Pakeha female school counsellor

Pakeha

Few comments were made on how Pakeha culture may affect suicidal behaviour, other than to note that Pakeha women seem more likely to access support services. For example:

“Pakeha girls seem a little more willing to seek outside help than Maori and Pacific Island girls”

- Pakeha female school counsellor

This lack of comment on Pakeha culture could be seen as an example of culture only being salient in relation to non-dominant groups. Dominant group members tend to see their culture as the norm, and it is therefore left unexamined. Although 10 of the 25 participants were Maori, the risk factors identified are largely reflective of Pakeha culture and the problems it poses (for example, alcohol, isolation of the nuclear family).

Social Class

The term 'social class' per se was not discussed by informants, with the exception of one Pakeha community worker who saw socio-economic status as underlying most risk factors. However, informants did speak of the stress within the family caused by factors associated with poverty such as poor housing and geographical isolation due to a lack of transport. Informants tended to associate this primarily with culture.

This was best explained by one participant's comment that:

Although ethnicity does not appear to be a major factor in itself,
some ethnic groups are certainly likely to be more at risk in areas
associated with low socio-economic status.

- Pakeha female clinician

This link between poverty and ethnicity was commented upon by most of the informants, arguing that Maori and Pacific Island girls and young women are more likely to be poor and at risk of a range of related factors associated with suicidal behaviour, than females of other ethnicities. In addition to the stressors of low socio-economic status contributing to risk, socio-economic status also impacts upon recovery, as will be discussed below.

Family Situation

Many informants described a lack of a sense of 'connectedness' as common among suicidal young women. This sense of social isolation, in some cases, was the result of not living with biological parents, exacerbated if caregivers had changed a number of times; in other cases it was coupled with, or attributed to, isolation from one's peers. Some informants mentioned adoption as a source of a sense of not belonging.

Most of the informants identified the breakdown of the family as a factor in many cases. This may result in the young person feeling neglected, as discussed below. In addition to more serious neglect, in some cases the issue is more simply one of the sole parent having insufficient resources to cope with a troubled young person. In other cases

Kids are not well-loved, or are parented in ways that do not communicate their value and worth. Parents don't know what to do, or how to communicate in a meaningful way.

- Pakeha male school counsellor

Several informants identified inadequate parenting as a factor. This may be due to external pressures on the parent(s), or a lack of parenting skills. Whatever the cause, the lack of a nurturing relationship was seen as playing a key role by several informants.

Parental substance abuse and parental suicidal behaviour were each identified as issues by two informants.

Neglect or Abuse

The overall impression gained from participant interviews is their view that the majority of young female suicide attempters have been abused in some form and/or neglected. It was noted that abuse and neglect tend to go hand-in-hand: "Abuse is common and may run the gamut from emotional verbal abuse to sexual abuse" - Pakeha female clinician

Those that are abused within the family are likely to be neglected also, and those that are abused by some one outside the family have often been preyed upon because they're neglected or isolated or withdrawn.

- Pakeha male school counsellor

Informants thought that family alienation may be part of the problem, compounded if this alienation has occurred because there are multiple abusers in the family, and this has led to the family breaking up:

As well as the girl feeling bad about the abuse and feeling isolated and alienated from her family, she may also be neglected because her primary caregiver's support systems have been removed, and she may feel guilty about that.

- Pakeha female community-based counsellor

Sexual Abuse. All informants identified sexual abuse as a very common risk factor.

However, it appears that it is usually an underlying factor rather than a trigger:

Sexual abuse may be part of the problem, but only part of it. It can be mitigated by good social and problem-solving skills and support.

- Pakeha female clinician

From some informants' reflections, it emerges that the key issue is how the sexual abuse is dealt with. It may lead to a loss of self-esteem, shame, a feeling of lack of control, and turning inward and isolating oneself, in turn leading to depression.

Nonetheless, if the abuse is disclosed soon after the event and appropriate counselling or therapy provided, informants believed that the consequences could be modified. However, most of the informants pointed out that it is not unusual for women to not be able to disclose sexual abuse for some years; often until they are aged in their 30s:

When working with teenagers you often see all the pointers – eating disorders, fear of being around men, discomfort or shame about sexuality and their bodies – but they don't talk about it. There seems to be an excessive amount of denial.

- Pakeha female community-based counsellor

Suicidal behaviour may be what they present with, but the problem is very, very frequently sexual abuse. However, it may take years for underlying reasons to come out. Often, the 'suicide attempt' is a cry for immediate attention, but it may take 15 years for them to be able to deal with the root cause of their troubles.

- Pakeha female clinician

The majority of informants spoke of suicidal behaviour as a way of young women taking control of their lives.

We most commonly see...abuse leading to a lack of self-esteem and feeling of lack of control, so the young woman tries to make a difference internally.

- Pakeha female community-based counsellor

Physical Abuse. Only two informants specifically mentioned physical abuse or violence in the home as risk factors, and it was not discussed in depth, other than to suggest a link between physical abuse and low self-esteem.

Neglect. Suicidal behaviour may be a way of getting attention for young women who feel neglected. This attention may come from medical professionals, social services or the family. Most informants highlighted the importance of emotional neglect as a risk factor. This lack of care may itself arise from a variety of factors, such as parental substance abuse or parents being absorbed in their own life problems.

It [suicidal behaviour] is a way of getting attention if they feel they're not getting the attention or care that they should.

- Maori female community-based counsellor

Emotional unavailability of the primary care-giver [is a major component]. Often the father is punitive and abusive, and the mother is downtrodden and passive. The expression of emotions is invalidated, and they [the young women] often have high anxiety as well as depression.

- Pakeha female clinician

In some cases parents were reported to be physically absent, resulting in there being no specific caregiver. Three informants mentioned the death of a parent – in some cases through suicide – as a factor. In addition, according to participants, young women who no longer live in the parental home may feel isolated from their family, or that they should 'stand on their own two feet'. Informants noted that in some cases the primary caregiver simply does not realise the extent of the individual's distress, in part because of her difficulty in communicating it.

Substance Abuse

Drug and alcohol abuse was considered to be a key risk factor by some informants. This may encompass substance abuse by the parents, but more commonly by the suicidal person. Although usually discussed as a risk factor in and of itself, it was also mentioned that drugs or alcohol may be used to block out abuse.

Personal Relationships

The demise of relationships with the opposite sex were seen by several informants as frequent triggers for suicidal behaviour:

Relationships tend to be very intense at that age [teenage]... especially if they're emotionally fragile anyway... when a relationship ends girls don't know how to cope. Inexperience leaves them feeling very vulnerable.

- Pakeha male school counsellor

Relationships are a big factor, especially for those with a history of abuse. Being dropped is especially bad, as they're desperate to have a relationship, to feel valued.

- Maori male social worker

Friendships were also identified as an issue for some, in a variety of ways that could be categorised as peer pressure or a lack of social skills leading to social isolation.

Loss

Some informants felt that a sense of loss was the key factor. This could be due to:

- family breakdown
- loss of innocence or childhood due to sexual abuse
- death of friends through suicide or accidents
- break-up of an intimate relationship

Lack of Self-esteem

Many informants spoke of a lack of self-esteem as a very important risk factor.

However, it seems that this was in fact usually secondary, as a result of, for example, neglect or abuse, feeling unloved, poor social networks or academic failure.

Power and Control

One participant suggested that suicide attempts are a form of control:

It's about taking control of your life when everything else seems to be outside your control. It comes out of powerlessness and it's usually an act of anger and revenge... against an abuser.

- Pakeha female community-based counsellor

Warning signs

Although not risk factors per se, informants identified a number of 'warning signs', indicators that a young woman may be suicidal. These included:

- being excessively angry
- excessive alcohol or substance use
- loss of pride in personal appearance or poor hygiene
- becoming emotionally labile
- loss of interest in activities previously enjoyed
- loss of appetite
- risk-taking behaviour, or an excessive number of accidents
- disruptive or attention-seeking behaviour
- preoccupation with death themes, for example in music or films

Clear statements by young women at risk of suicidal behaviour about how they feel are not uncommon, but are frequently not taken seriously, which can be construed by the women concerned as further evidence that they are not valued.

As discussed above, some informants noted that depressed girls tend to become quiet and withdrawn, therefore they are not noticed; boys' distress is usually expressed more visibly. Two informants mentioned that girls may go through a period of 'externalising', being disruptive, for example, but when they become seriously depressed they become withdrawn and introverted, and this is when they are at most risk of suicidal behaviour. In addition, it is not considered unusual for young people to be 'moody'. Further, the young person's behaviour may be quite normal given the context of their family situation.

One participant noted that people from different communities and cultures display distress in different ways, which makes it hard to recognise potential warning signs.

Summary

In conclusion to this section, all informants felt that depression was a factor for almost all young women who engage in suicidal behaviour, and co-morbidity was common. All informants mentioned contributing social factors, but while some informants saw this as secondary to pathology, others considered that social factors underlie depression and therefore are of primary importance. These factors include family dysfunction including abuse, low self-esteem, poor social networks, substance abuse and relationship break-up.

Cessation

The following section deals with cessation and recovery. It begins by presenting findings in relation to key facets of recovery, before exploring interventions and the specific treatment procedures used and recommended by the informants.

Cessation and Recovery from Suicidal Behaviour

It is important here to make a distinction between cessation and recovery. Langford (2002) discussed this as the difference between feeling better and getting better. In the former, the individual experiences a decrease in suicidal behaviour; in the latter, they are developing coping strategies, problem-solving skills or working on underlying issues and, therefore, are less likely to become suicidal. Individuals may, for example, cease their suicidal behaviour because they have increased use of substances in a morbid attempt to self-medicate. While these individuals have achieved cessation, it could not be said that they have truly recovered.

Among the informants working from community organisations and schools, the key factors in recovery were building self-esteem, social connections and a sense of control.

Family alienation may be a significant problem, especially if there are multiple abusers within the family. Several informants felt that counselling was not always important, that it could be better to have a 'lay' person the individual can relate to,

such as a member of the extended family or a teacher. Two informants felt that the level of care and support received from friends after a suicide attempt is often quite unexpected, and this affirming that they are loved and wanted can be sufficient to affect recovery. At the same time, two informants felt that family and friends may make the situation worse if they are not given help to deal with it. Several informants felt that often the development of an intimate relationship can have a major effect on self-esteem. Although in some cases this may only last as long as the relationship, for others it seems to provided the 'boost' that is needed to develop in other positive ways, such as developing other friendships.

Informants working in clinical settings also mentioned the topics discussed by community-based workers, but tended to discuss treating pathologies at greater length. This may include medication or specific therapies such as cognitive behavioural therapy, or hospitalisation.

Current Treatment Procedures

The discussion of risk factors commenced by noting that informants working in the mental health system tended to describe risk factors largely in terms of psychopathology, while informants working in community organisations identified life events or social circumstances. These perceptions were carried through to informants' attitudes and beliefs about effective treatment procedures. Informants tended to be of the opinion that their own modality of treatment was the most effective.

Overall, informants gave the impression of believing strongly in the efficacy of the paradigm that informed their work, regarding it as the most appropriate. For example, counsellors felt that counselling was the most successful intervention, while informants within the health system relied more heavily on clinical diagnoses and medication. This in itself is unsurprising. However, some informants were very strongly critical of others' methods. All of these criticisms were aimed at those working in a medical setting.

We hear some dreadful stories about those working from a medical model...people are expected to fit into categories and are treated as

patients, not human beings.... in some cases the ability to prescribe meds has helped people over an acute phase, but control is in the hands of the doctors...we've heard of punishment meted out by doctors and nurses; a nurse told a woman who later came here how she could 'do it properly' - how to kill herself.

- Pakeha female community-based counsellor

All too often suitability of prescriptions appears to have not been considered fully. For example, I know of many women who have been given a month's supply of medication following a suicide attempt, with no thought given to their safety. An alarming number that have overdosed used prescribed medication.

- Pakeha female community-based counsellor

One of my clients had previously called an emergency service who put her in a geriatric ward. She was virtually ignored by staff. She was there for four days before she saw a counsellor.

- Maori female community-based counsellor

Those that go to hospital are automatically referred to a government health agency, but often not to a specific person – just whoever's on duty, so continuity is a problem, leading to an impersonal service. Clients who are known to have made more than one attempt are not given priority for help other than medical. One of my clients had previously been refused counselling [by hospital staff] as a punishment for breaking her agreement not to make an attempt. The attitude of staff often seems punitive or in some cases the other extreme – being 'rescued', which is just as bad as it's disempowering. Over-medication is also an issue.

- Pakeha female community-based counsellor

Criticisms were also made of the inequities in agencies' resourcing, pointing out the impact of resourcing on clients, particularly for community agencies.

Money is such an issue – for our clients, and for us! People pay what they can afford, and we have some one whose job it is to chase funding, but it's always a struggle.

- Pakeha female community-based counsellor

I find working with the family to often be most effective, but you can spend 3 hours working with a family, and they may be struggling to pay \$20.

- Maori female community-based counsellor

Although [mental health service] has psychologists and psychiatrists on staff, they seem to do little other than classify patients with a disorder and refer them on – to organisations like us. They have so much more funding than us, but we're left to do the hard work.

- Pakeha female community-based counsellor

As one community counsellor noted:

Survival of the attempt is just the beginning of the road. Suicide is an attempt to get control - it's the only thing they feel they have control over, so we ask what other things they can take control of. Becoming aware of their own power and responsibilities - but it's very slow work.

- Pakeha female community-based counsellor

Apart from differing perspectives on the importance of diagnoses and medication and issues around resourcing, most informants from both groups agreed that there were several key areas to be addressed in treatment. These included:

- Developing self-esteem and a sense of possibility in the individual
- Fostering social skills
- Forming successful links into school or courses that provided direction, and achievement
- Advocating with other services, such as Work and Income New Zealand (WINZ), Child Youth and Family (CYF) or budgeting services
- Ensuring safety if abuse is a factor

- Developing problem-solving skills
- Instigating classes to deal with learning difficulties when appropriate
- Dealing with the factors that triggered suicidal behaviour, such as bullying or relationship issues
- Establishing a safety plan, such as crisis strategies and access to emergency services

Many community-based informants also spoke about:

- Fostering a sense of connection to their community, for example, through extended family, friends' families or youth groups
- Making a personal connection with the individual, not just intellectually, but emotionally and spiritually
- Creating an environment in which they can express their feelings honestly

Many informants discussed the importance of working with the family, particularly those working in the community, but noted that this was not always possible. Family members may not be willing, especially if there is abuse within the family, and there may also be financial constraints. The issue of the family acting as a barrier to treatment is discussed below. However, informants said that, when possible, family therapy may consist of developing effective communication skills, negotiating boundaries where independence or over-protection is an issue and encouraging parents to enrol in courses such as parenting skills or anger management.

Friends were also identified as often being a part of the problem:

Friends are often in a similar space, or they have few friends. Helping to develop self-esteem may mean leaving friends behind as they're outgrown. We have to help build new relationships.

- Pakeha female school counsellor

Given that many informants felt that sexual abuse was a common risk factor, few informants spoke of dealing with sexual abuse issues. One agency specialises in sexual abuse cases, and they stressed the importance of building a trusting relationship and spoke of the long process that may be involved, before informants are able to talk about abuse. Conversely, one participant, a Pakeha clinician, stated

that she had found unwillingness to disclose sexual abuse to rarely be an issue: “You don’t necessarily have to wait for an explicit disclosure. There are ways in which you can enquire.” Presumably this enquiry must be very sensitive if an appropriate and non-suggestive approach is to be taken. As will be discussed in Chapter Five, a very common theme that emerged in interviews with women who had made suicide attempts, was the importance of not being pushed to talk about sensitive matters before the individual is ready to disclose.

Ethnicity

In addition to the aspects of intervention that are applicable to most young women, some informants (from all groups) identified additional factors that may be appropriate for members of different ethnic groups.

Several informants commented on the difficulty young Maori appear to have in accessing services: “Maori don’t know what services are available, and they’re often not comfortable going to a mainstream service”.

- Pakeha female clinician

Informants could be divided into three groups according to their way of dealing with different ethnic groups.

Some services were targeted primarily or exclusively at young Maori. There are also services that target Pacific Island and Asian youth, although they were not included in this research.

Secondly, two informants working in mainstream organisations mentioned incorporating the services of a Maori health worker when working with Maori youth:

We may work differently with the family, providing cultural supports... For example, utilising whanau classes at high school, social services based on marae, organising respite with a Maori family – if it seems important and the client wants it.

- Pakeha female clinician

However, informants noted that in small communities it may be difficult to find a counsellor of the same ethnicity as the young woman, who is not known to her.

Thirdly, other informants spoke of cultural sensitivity and appropriate treatment being inherent in their philosophy of treating all clients with sensitivity and respect according to individual needs. Therefore they did not provide specific services for different ethnic groups. A few informants had no comments to make in regard to providing a culturally appropriate service.

In addition to different ways of dealing with clients according to client ethnicity, several informants also spoke of differing reactions of individuals' friends, based on ethnicity.

The reaction [of Maori girls] is almost like a tangi – there's a huge outpouring of emotion then it's over, whereas Pakeha girls tend to intellectualise it and pick it apart for much longer.

- Pakeha female school counsellor

Maori girls tend to come [to counselling] with friends, but that might be partly because we're more likely to suggest they bring a friends.

Maori girls do sometimes ask if they can bring some one, but Pakeha girls almost never do.

- Pakeha female community-based counsellor

Contact with Other Agencies

Two community group informants mentioned difficulties in accessing information that could be beneficial, such as information from schools or CYFS, difficulties they attributed to the Privacy Act. This could include being kept informed of foster care arrangements, for example, and informants discussed the often untapped potential for working in tandem with a school counsellor or social worker to develop effective strategies.

Another informant mentioned problems with contacting agencies such as CYFS in cases where abuse was a factor; the individual may not want the agency contacted and see it as a betrayal, but the counsellor feels an obligation to do what she can to ensure the individual's safety. The response from CYFS had also been a cause for concern on a number of occasions.

Barriers to successful treatment

The most commonly mentioned barrier to treatment was a lack of support by the family of the young woman concerned. This was usually considered to be a part of the original set of risk factors: the family is dysfunctional or under stress and this contributes to both the suicidal behaviour and difficulty in accessing treatment due to transport and/or financial difficulties, or a negative view of treatment by the parent(s). There may be a deep sense of shame about the suicidal behaviour in some families, which results in reluctance to seek help.

Reluctance to disclose abuse was a barrier discussed by several informants, working in a variety of settings. Although there may be a number of signals that a young woman has been sexually abused, until it is disclosed it cannot be dealt with, and as this may be a fundamental issue leading to the suicidal behaviour, it is difficult to make real progress in counselling or therapy.

Although we certainly have teenagers disclosing abuse, many of our clients are women in their 20s and 30s who were abused as teenagers and have only just reached the point of being able to talk about it.

- Pakeha female community-based counsellor

It should be noted, however, that one informant felt that it was not necessary to wait for a disclosure; that it was possible for the therapist to broach the subject.

In addition, two informants mentioned the possibility of the reaction to suicidal behaviour acting as a reinforcer. The first time the young woman attempts suicide she may be rewarded with concern and nurturing, and so continues to engage in self-harming behaviour. This can create a dilemma for caregivers who have to respond appropriately without reinforcing the behaviour.

Young women may not want their family to know of their suicidal behaviour because of concerns about their reaction. Notwithstanding a possible obligation for counsellors to inform parents dependant on the girls' age, clients not informing their parents may experience difficulties in accessing services, due to a lack of resources or the need to explain their absence from home.

In conclusion to this section, there was a definite difference in the emphasis placed on the importance of diagnoses and medication among the informants, with many informants from community agencies being strongly critical of agencies working from a medical model. However, there were a number of areas that almost all informants agreed were important for recovery. These can be broadly categorised as building self-esteem, developing personal skills, practical measures such as ensuring safety from abuse or aiding the return to employment or education and building supportive social networks. Some informants also discussed specific interventions for Maori. There were a number of factors that could affect the success of counselling or therapy, primarily lack of commitment on the part of both the young woman concerned and her family, for a number of reasons. Difficulty in creating or sustaining interagency networks was an issue for some informants.

Prevention

Informants mentioned a number of possible areas for prevention, but overall contributions on this topic were limited compared to risk factors and interventions. Most of the suggestions offered related to community and teacher education. The initiatives mentioned were:

- Increased education about depression and warning signs, for teachers and the community generally
- Support for family and friends, both for those concerned about an individual's well-being, and following suicidal behaviour. This includes greater publicity about and funding for existing services.
- Community education on mental illness, particularly dealing with stigma about depression.
- Compulsory life skills courses in all schools, taught from an early age. "It's all very well to know your maths and English when your life is falling apart"
- Promotion of positive communication in schools, both verbal and non-verbal, including teachers as well as students
- More extensive teacher training on mental health in young people. This should include recognition of the links between behaviour problems and underlying stress
- Develop safe rooms and peer support groups in all schools

It should be noted that some of these suggested initiatives have become available in recent years. For example, Suicide Prevention Information New Zealand (SPINZ) has several community information kits available; the former Health Funding Authority instigated a 'Health-Promoting Schools' programme which incorporates basic mental health awareness.

This chapter has outlined Component One informants' perspectives of key risk factors for suicidal behaviour in young women, reporting that in addition to the psychopathological approach seemingly privileged by some of those working from a medical model, a range of social factors are relevant, particularly relating to poverty, abuse and neglect. Many informants considered that young Maori and Pacific Island women are at greater risk of exposure to a range of factors. Informants' beliefs about cessation and recovery were also presented, with key aspects detailed. The chapter concluded with a brief outline of prevention strategies.

CHAPTER FIVE: COMPONENT TWO CASE HISTORIES

This chapter begins by outlining the demographic characteristics of the participants at the time of their first episode of suicidal behaviour. This is followed by participant profiles, which broadly discusses the circumstances surrounding each individuals' suicidal behaviour, the behaviour itself, and the cessation of suicidal behaviour. The purpose of these profiles is to provide context to the material that follows in the next chapter: collation of the findings from the interviews.

Demographic Characteristics of the Participants

As discussed in Chapter Three, efforts were made to recruit participants from a variety of backgrounds, in an attempt to obtain a sample as representative of the population of interest as possible, given the sample size. The following tables gave demographic information about the 24 participants at the time of their first engaging in suicidal behaviour.

	Rural	Town	City ²⁵
Pakeha	4	7	10
Maori		2	
Asian/ Pakeha			1

Province:	
Northland	1
Auckland	5
Waikato	4
Taupo/Central	1
Bay of Plenty/Coromandel	3
Wellington/Wairarapa	2
Nelson/Marlborough	2
Canterbury	3
Otago	2
Undisclosed	1

Table 5: Participants' ethnicity and geographical location at the time of their first episode of suicidal behaviour.

²⁵ Denotes the geographical location in which the participant spent the majority of their lives prior to suicidal behaviour.

Self-Mutilation

Thirteen participants had mutilated themselves before their first suicide attempt, and most continued to self-mutilate after their attempt(s). Four began mutilating after their first attempt. Three had self-mutilated within the six-months prior to the interview, and one was continuing to self-mutilate at the time of the interview. In total, 17 of the 24 participants had self-mutilated at some time. Three participants mutilated themselves five times or less, while the rest mutilated themselves six or more times, in some cases on a daily basis for a period of weeks.

The most common form of self-mutilation was cutting; indeed, all but one of the self-mutilators had cut themselves. Four participants also burnt themselves, and one scratched herself to the point of bleeding. Additionally, 18 participants engaged in (arguably) less aggressive forms of self-harm, such as substance use, or disordered eating or over-exercise.

The age at the first episode of self-mutilation ranged from 11 to 25 years. The average age at first mutilation was 16. Three participants were hospitalised for self-mutilation once, and one person was hospitalised several times, leading to a total of approximately 8 hospitalisations for all participants. In addition, 8 participants have been treated at accident and emergency rooms for self-mutilation, without being formally admitted. Medical treatment involved suturing or burn treatment. Three participants had been hospitalised for eating disorders.

Suicidal Behaviour

The participants' living circumstances at the time of their first attempt varied, but just over half (13) were living with one or both parents. Of the remaining 11, six were living in shared accommodation, two were living in de facto relationships, one was living with foster parents, one with extended family, and one participant was living full-time in boarding school (including holidays).

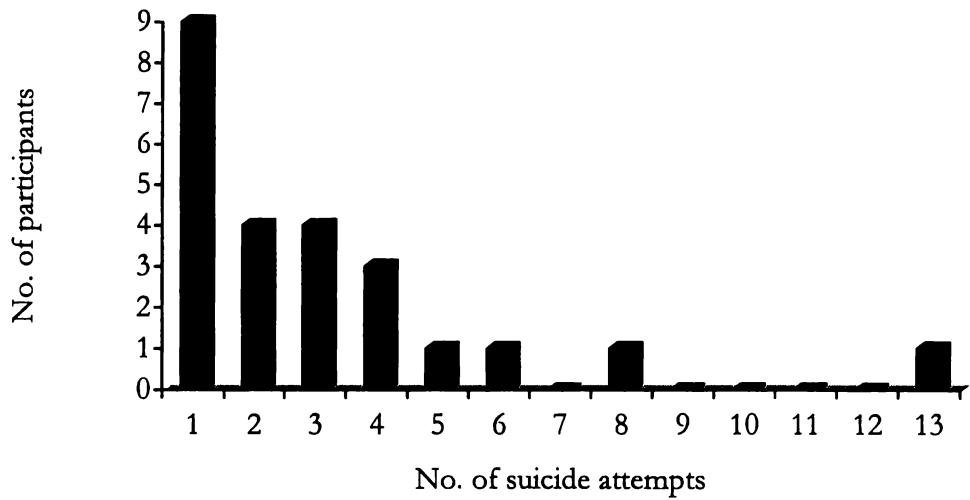
The mean age of participants at the time of their first suicide attempt was 17, with the range being from 8 to 25²⁶. Table 6, below, provides a breakdown of the 24 participants' ages at first attempt.

	< 11	11 - 15	16 -20	21 - 25 ²⁷
Pakeha	1	3	14	3
Maori		1	1	
Asian/ Pakeha	1			

Table 6: Participants' age at time of first suicide attempt.

While the majority of participants made one attempt, the number of attempts made ranged from 1 to 13, with three being the average number of attempts made. Figure 2, below, provides a graphic illustration of the numbers of suicide attempts.

Figure 2: Number of suicide attempts made by participants.



The most common means of attempted suicide was drug overdose, with 22 of the 24 participants using this method at least once. Six participants cut themselves (some

²⁶ An upper limit of 25 at first attempt was one of the parameters for recruiting the sample.

²⁷ Denotes age at time of first suicide attempt.

on more than one occasion), and hanging, gassing and electric shock were each tried by one participant. Medication prescribed for depression or anxiety were used by half of those overdosing (12 instances), although Panadol was the single most common medication used (seven instances), often in combination with alcohol. Other substances or a combination of substances were used in 8 instances. In four instances participants were either unsure of what was taken, or did not disclose this information.

Thirteen of the twenty-four participants had been admitted to hospital for a suicide attempt, most to have gastric lavage or administration of an emetic. Eight participants had been hospitalised once, three hospitalised two or three times, and one person hospitalised at least 10 times. This totals approximately 23 hospitalisations. Admission periods ranged from one day to one year. The usual pattern appeared to be emergency treatment followed by several days' observation, then either discharge or referral to the psychiatric ward.

Three participants had been treated as out-patients once, one person twice, one person four or five times, and one person at least six times, usually for cut wrists. It should be noted that medical staff did not appear to recognise injuries as self-inflicted in approximately five incidents involving three participants.

All of the participants made what they considered to be serious suicide attempts, that is, they actively wanted to die. However, some participants also engaged in behaviour that could be called a 'cry for help'; that is, they felt desperate and believed the only way they could draw attention to their plight was through appearing to attempt suicide. One of these participants was ambivalent; she would have preferred to get help, but if that help was not forthcoming, then death was an acceptable alternative. In addition, three participants intended to die when taking overdoses, but then became afraid of dying and summoned help.

The relationship between self-mutilation and suicidal behaviours is discussed in Chapters Six and Seven. The remainder of this chapter consists of profiles of the 24 participants in Component Two of the research. All names have been changed.

Anna

Anna is a Pakeha woman, born in 1963. Although her childhood and teenage years were spent living in the city, she spent her holidays in rural locations. Anna described her parents' marriage, and her up-bringing, as 'not ideal'. Her father was seldom home due to his occupation, but the family was fairly privileged in terms of resources. She said her parents did their best, there was no question of abuse, but there was a lack of care. Her parents' relationship has left Anna very wary of relationships and men.

Anna made one deliberate suicide attempt, at the age of 18. This was in the form of an overdose, for which she was hospitalised. Anna also described other harming behaviour, such as taking quantities of over-the-counter drugs, to see what would happen, if any-one would notice, without consciously planning to take her life.

Anna considers herself to have been depressed throughout her childhood, which she attributes to pressure to succeed, both at the time in terms of schoolwork, and in life generally. Anna sees the key precipitator of her suicide attempt as an accident in her 7th form year. The injury was not treated properly, and she eventually had major surgery months later, in the middle of her final exams, and remained in hospital over Christmas. The injury had a major impact on Anna's self-esteem. Anna identified herself as having been a 'very sporty, Christian, good girl', and the injury shook her self-identity. She also identified the 1981 Springbok tour (which occurred the same year) as having a big impact on her perceptions of the world and her community. The following year Anna went to university. She had had little contact with young men and had a sheltered up-bringing, and found suddenly being amongst a large population of male students difficult to cope with. Her response to this was to "jump into bed", despite being a Christian and a virgin. The young man concerned boasted to his friends about sleeping with a virgin, with the result that Anna was taunted and bullied for weeks. She was also struggling academically so turned to alcohol to cope. The feeling of failing, both personally and academically, resulted in the suicide attempt. Anna was admitted to intensive care, where her stomach was pumped, and her parents called. When her parents arrived, her father shouted at her,

while her mother said how disappointed she was. Anna was subsequently transferred to a psychiatric ward for a week, before being taken home by her parents.

Although she had seen a psychiatrist while in hospital, Anna did not have any form of follow-up or counselling after her discharge because her family were concerned about the impact of her suicide attempt on the family name. Her friends did not know what had happened, so Anna received no support. During this time Anna began drinking heavily and attempted to ignore the suicide attempt and the issues that led to it. She decided she was not intelligent enough to return to university and did not know what to do. She said she would have been happy to take up a hairdressing apprenticeship but was afraid of not succeeding and got work as a farmhand. Shortly after this Anna decided to travel overseas with a friend. While in London Anna became involved with some heroin addicts. Through these associations she realised there was more to life. At this point she made a conscious decision to take charge of her life.

Anna described the suicide attempt as a call for help. She had been seeing a counsellor at university, but this had not helped her. She said there were no thoughts of making another attempt, as the first did not achieve anything, and in addition she had had to cope with her parents' negative reaction.

Anna said the biggest lesson was about the impact a suicide attempt has on the people around you. She said she still feels paranoid about people knowing that she "had a breakdown". When depressed she will see a counsellor, and has tried Prozac, but did not find it helpful; it left her feeling numb, and did nothing to remove the source of her "emotional depression". Anna said that initially she had a "poor me", "heart on the sleeve" attitude, but found that people judged her. "There is a definite stigma".

In Anna's opinion, there should have been much more support, not just for her, but also for her parents. Her suicide attempt was never talked about. Society seems to provide little care for individuals. Anna said that there are some good counsellors, but it seems to be a matter of luck as to whether you find one. She feels that for services to improve, as a society we need to give more support, to be proactive. We need to consider what is important – health and education for the nation and remembering that people are our major resource. She believes that children's

depression needs to be recognised and dealt with by teachers and families. Mental health education could begin with Plunket.

Collette

Collette was born in 1976 and is a Pakeha. Her father is schizophrenic and at times very violent. When Collette was seven “it all blew up” and her parents split up. At the time of her parents’ break-up Collette felt responsible for the rest of the family. Her birth father subsequently married a fellow mental patient and Collette used to stay with them for holidays. Collette’s stepmother tried to commit suicide in front of her. Collette’s mother also re-married, and Collette’s stepfather was verbally abusive and seems to have been unable to control or direct his anger appropriately. He was not physically violent to people, but was to animals and property. Collette continued to feel that she had to protect others and stand up to him.

Collette was depressed for several years in her teens, feeling that she could not connect with anyone. She had a boyfriend from age 17 for four years, who was very controlling of Collette’s behaviour. This relationship seems to have spurred some self-harming behaviour; Collette described hitting herself if she was upset with him, and wanting to crash her car. He was offered the opportunity to move to England, so they broke the relationship off, which was the lowest point for Collette emotionally. Collette felt rejected, mostly by her birth father, but by others also. Although there had been some problems in her relationship with her boyfriend, she was able to talk to him and he understood how she felt, and made her feel loved and cared for. Collette was quite shy and had few friends so she felt like a loner without her boyfriend. Collette’s mother tried to be there for her kids, but she was always very busy and committed a lot of time and energy to helping others. Collette felt like she did not have the strength to live, and she became suicidal. Collette spent several months thinking about suicide. One evening she gathered up medication from the bathroom cupboard and took this along with a moderate amount of alcohol and went to bed, expecting to die. However, she woke up during the night feeling nauseous. She was sick then went back to bed. She awoke the next morning feeling groggy and unwell, but without further complications. Although she continued to think about suicide for some time, Collette did not make another suicide attempt.

Collette said it is hard to pinpoint what had changed and how she got over her suicidality. She said her life purpose had been looking after the family and thinking about her younger siblings kept her going. Shortly after her suicide attempt Collette talked to her sister about how the past had affected them and this seems to have been a turning point. In addition, a relative committed suicide, and when she went to the funeral, it made her evaluate her life and her purpose. Travelling has helped also; Collette had felt stuck in a routine with no direction, but travelling overseas increased her confidence and independence. Collette also met an older woman who was very caring and spiritual, and provided an avenue for Collette to express herself. Collette found her very affirming and her confidence increased as a result of this relationship. Collette has never received counselling or other therapy.

Dana

Dana was born in 1973 and is a Pakeha. Dana's father died when she was 10. Dana's mother has suffered from depression, and at times has felt suicidal. Other than this, Dana considered herself to have had a normal childhood, but she was shy. She had few friends after puberty and left school at 14 – she had been in some trouble for skipping school and smoking.

Dana's family had counselling after the loss of her father. His death left her feeling devastated, and she experienced periods of depression through most of her teen-age years. Dana's depression increased after the birth of her first child when she was aged 18, and has continued to suffer depression since then. After the birth of her child, Dana appears to have suffered from post-natal depression: she felt like harming the baby. Dana turned to alcohol to cope, giving the baby to her mother to look after. During this period she had relationship problems and began thinking about suicide. On one occasion she wrote a suicide note, but did not act on it. On another occasion she took an overdose, but the only effect was to make her feel ill. She did not receive medical attention, but a few days afterwards decided to seek help from her doctor, with her mother's encouragement. Dana says she was a "loner" at the time of her suicidal behaviour and therefore had no support from friends.

Her doctor sent Dana to a counsellor. This counsellor believed that Dana was abusing drugs, despite Dana's protestations. This lack of trust was difficult for Dana,

so she stopped seeing the counsellor. She then saw another doctor who appears to have been of more help. He prescribed Prozac, and worked with Dana's mother to support her. This doctor suggested Dana have counselling for alcohol abuse, but Dana's mother discouraged this, as she did not think there was a problem since there was a family history of heavy drinking. Dana did not find counselling to be of help because of conflict about her drinking. Dana decreased her dosage of Prozac, partly because it interfered with her drinking. A friend of Dana's mother who is a psychiatric nurse involved another doctor. Dana told him that she wanted to kill herself but she did not want to hurt her mother. This doctor wanted to admit Dana but she refused, so it was decided that Dana should stay in her mother's care, and be a voluntary day patient. This seemed to help her, but Dana had difficulty articulating exactly how it helped. It largely seemed to be having somewhere to go where she felt people cared about her.

Dana still suffers from depression and seems to rely very heavily on her mother. She has not had counselling for several years apart from for parenting issues. Dana and her mother "have reached out for God" and this faith has helped.

Evelyn

Evelyn was born in 1978. She is a Pakeha. When Evelyn was four years old, her parents' marriage became troubled, and her father eventually left the family home when Evelyn was nine. However, her parents never formally split, despite continuing conflict; her father would return for brief periods but did not return to the home long-term. Evelyn said she had always had morbid thoughts; even as a very young girl she would talk about dying and had dreams about killing herself. However, she said she was generally a happy child through until her early teens. Evelyn became involved in sport at age 10, and within a few years became the New Zealand women's champion in her chosen sport. She said there was a lot of emotional pressure associated with this. She was expected to continue to do well and to spend hours practising before and after school. The combination of this pressure, doing poorly at school and the situation at home lead to her becoming depressed. She said she felt different to her schoolmates because of her sporting commitments and achievements. Her father gets depressed, and her grandfather is an alcoholic, so she thinks there may be a genetic link.

When Evelyn was 13, her older brother developed severe mood swings and at times was suicidal. Evelyn had always looked up to her brother, and she thought that if her brother could be suicidal, then it was acceptable for her too, but she said she would have thought about it anyway. Evelyn started taking anti-depressants at the age of 14. The doctor who prescribed them did not suggest other support, apparently feeling that drugs were what she needed at the time. She took the medication for two years but did not feel they were helping, so she discontinued them. However, her distress increased from this point. At age 16 Evelyn started cutting herself, which she described as an expression of anger with herself. She was not enjoying anything, and her life revolved around training and school and concerns around her weight. Her father called her a 'fat cow', telling her she would do better in her sport if she lost weight. Her sport continued to be a source of stress for her; she felt she had reached a plateau, and there were problems with coaching. The family also had financial problems, and had to sell their home.

At this point Evelyn made a definite plan to kill herself, using her brother's sleeping pills. She had heard that when a person dies, their bowels and bladder evacuate, so she decided to starve herself for three days, and then take the overdose. However, her mother became suspicious during this preparation phase, and confronted Evelyn, taking away the pills. Evelyn felt that she could not go through with a suicide attempt, once her mother knew her intentions.

Although Evelyn did not make another suicide attempt, she continued to cut herself for two years. Evelyn said the cutting was usually not suicidal, but a release of emotion: "It does hurt, but it doesn't matter because you feel like you deserve to hurt. The internal pain is far worse than the physical". Sometimes cutting could be a way of dealing with feeling suicidal, releasing the pain instead. Evelyn has never received medical attention, counselling or other support for these issues.

Although Evelyn and her mother talked after the interrupted suicide attempt, it did not resolve anything. However, it did make Evelyn realise that her mother needed her, preventing further suicidal behaviour. She was also concerned about the possible spiritual consequences of killing herself, in regards to karma and going to hell. Evelyn said that if it was not for her Mum and those spiritual concerns "I know

I wouldn't be here". Friends did not know what to do, and by the time her friends found out what was happening, Evelyn did not want to be helped. She said that some people seem to think it is a choice to be depressed or suicidal, and they get frustrated with it, and "can't be bothered". Evelyn said the man who would become her husband was her biggest support. She also said she stopped cutting because he threatened to leave her.

Evelyn still thinks about suicide sometimes, but not every day, as she once did. Sometimes Evelyn feels like she cannot see another way out of problems, but she never actively does anything suicidal. She does not think her suicidal feelings will ever completely disappear. Evelyn thinks her husband is an important factor in her not acting on these feelings, and notes that if something were to happen to him she might act on them. However, she now tries to think about her feelings objectively, to understand why she is feeling down and think of ways of dealing with it.

Evelyn said that even if she had someone to talk to about her depression and suicidal feelings, she doubts it would have been helpful at the time. She said she was too caught up in her feelings, totally irrational, and could not look at things objectively. She did see a sports motivator when she was aged 16 and ended up talking to her about her relationship with her father. This made her feel a lot better "so it did help to talk to some-one". Evelyn also saw a school counsellor who "just brushed me off – talked about how well I was doing in sports and stuff she wanted to talk about [she] didn't hear what I was saying".

Hayley

Hayley was born in 1979 and is a Pakeha. Although there was some physical abuse in her family – her parents would assault Hayley and her siblings – Hayley is unsure of how much of an effect this had on her in terms of her subsequent self-harm. She has a sense of not being happy as a child, and of wanting to please people. Although she has difficulty pinpointing the specific factors involved or how she was feeling when her self-harm began, at the age of 11, she said she had general low self-esteem. She did not have anyone she could talk to who she felt she could trust. Her family had never talked about personal things, so although she had friends she found it hard to talk to them.

Hayley started burning herself at the age of 11 or 12, after being burned accidentally, and picking at the wound. She also began bruising herself, and developed anorexia at around the same time. Hayley began to burn herself as a punishment for eating, and also because she was tired of worrying about calories and food; burning provided another focus. Although Hayley did have some medical treatment as a teenager from her GP for burns, which sometimes got infected, she said they were accidental. At this point nobody realised Hayley was deliberately harming herself. Her mother commented on her weight loss, but did not seem particularly concerned.

When aged 17 Hayley's self-harm became more actively suicidal, and she started to cut her wrists. No medical attention was received. She said she was sick of everything: the eating disorder, not being happy at school or in her family. She felt helpless, and felt that she was wasting people's time. She also realised she is a lesbian, and was teased about this. She said she could not pinpoint any one particular thing that made her feel suicidal; it was a combination of factors. Burning herself helped to alleviate her suicidal thoughts. It was like a pressure release "it was my best friend in a way". At the age of 17 Hayley was hospitalised for anorexia.

Hayley's friends had commented on her eating habits, and one friend confronted her about it. Hayley tried to brush it off, but the friend persisted, and Hayley broke down and admitted that she had a problem. Hayley initially did not want anyone to know. She said she was afraid that people would think that she was a freak. Her self-harm was giving her a focus and felt like a comfort. It was around this time that she became actively suicidal. Hayley's friends consulted the school guidance counsellor, because they were worried about her. The school guidance counsellor told Hayley that he was going to talk to her parents about her. Hayley asked him not to, but he insisted. Hayley did not go home that evening until hours after he had left. Her parents never said anything about it, but Hayley felt betrayed, and it took her a long time to be able to develop trust in a counsellor as a result. She did not see him again.

The school counsellor referred Hayley on to an eating disorder counselling service, who Hayley also did not feel happy with. She only saw staff there once, having been coerced to by the school counsellor, and was just referred on elsewhere. This service

referred her to a hospital-based anorexia programme. Hayley was treated as an in-patient, a day-patient and an outpatient, over a period of approximately two years, from the age of 17.

Hayley's friends were concerned about her while she was in hospital and visited her, but her father told her to "pull [her] socks up" and did not feel she had a valid problem. Hayley's mother attended two meetings at the hospital, but Hayley's father strenuously objected to her mother going. As a result, Hayley felt worse about herself, and felt that she was wasting people's time. Hayley thinks it would have been helpful if there had been more family involvement in her treatment.

Hayley said that the hospital dealt with her burns really well; "they were matter-of-fact and didn't make a fuss". Other medical professionals were less understanding. One health centre nurse made her feel guilty by saying "there are *real* sick people here" and others have made similar negative comments.

Hayley's eating disorder has continued until recently, and she continues to harm herself by cutting and burning. She has not been actively suicidal for approximately four years. Hayley said that it is hard to pinpoint specific things that were helpful. She thinks that if her mutilating and eating problems had been discovered earlier they might have been easier to deal with, and if her school had not been so focused on weight charts it might not have seemed like such an issue. In addition if her parents had given her more positive attention the self-harming probably would not have arisen. Having support from people is important, such as the workers at the eating disorders service she now sees. Finding a place with people she can trust and respect has made a real difference. Hayley says that timing is also important. She needs to have time to work things through and sometimes in counselling or therapy she has felt pressured to achieve goals. Hayley's current doctor is understanding and supportive. She is now on a sickness benefit, which releases her from the pressure of being expected to find a job. Her partner has also been a great support over the last two years, and it is possibly this relationship that keeps her from being actively suicidal.

Heidi

Heidi is of European descent, born in 1977. Her parents divorced when she was 18 months old, and she then lived with her mother, rarely seeing her father. Heidi described her family as very dysfunctional. Heidi was sexually abused by her maternal grandfather, and disclosed this when she was aged seven or eight and was caught sexually abusing another child. Heidi's mother had a breakdown as a result of this disclosure. She had blocked out her own history of abuse by her father until a year prior to Heidi's disclosure. With hindsight, Heidi believes that the events that occurred after her disclosure had a far greater impact than the abuse itself. Heidi and her mother were virtually disowned by the rest of the family and the grandfather refused to get help. Heidi's mother felt she had no choice but to stop seeing her family, who had been a huge source of support, and Heidi had been her grandparents' "princess".

Eventually Heidi began counselling which continued for 10 years. Heidi's mother took her to church for prayer, but this did not help. Her grandfather had said that "God said it's all right to do [abuse]", and the church said that Heidi and her mother should "forgive and forget" so Heidi lost faith in the church. Heidi had a lot of anger, had lots of nightmares and developed an eating disorder. This was exacerbated by the boarder they had at the time who was bulimic and would comfort Heidi with food and initiated the use of 'things' (food and, in later years, drugs) as coping mechanisms to mask emotions.

At around the age of 12 Heidi drank a bottle of muscle relaxant with a large quantity of Panadeine. She described this as being a combination of attention-seeking and unconcern about the consequences. She received medical attention and was administered an emetic and continued with counselling. At 13 Heidi went to a Christian camp and had "the spirit drawn out". This confirmed her feelings of being "evil, nasty, fucked in the head". She also had difficulty dealing with the fact that she had been abused but her cousin had not. The next year Heidi began scratching herself for long periods of time, resulting in friction burns.

At age 15 Heidi decided to initiate court proceedings against her grandfather. It was this decision that led to Heidi becoming suicidal, a feeling of "everything's a disaster". Heidi had an evidential interview which was crucial to how things

developed. She hated herself, wanted to die and was very depressed. The interview “was fucking horrible”. Heidi sees a link between the abuse and her feeling bad and evil, so she gravitated towards doing things, or being with, bad, evil people. Looking back, prior to the court case, everything had been going well. Heidi made friends easily, and although she had difficult times, on the whole things were manageable. However, in the next year Heidi was put into a class with a “crappy, humiliating teacher”. She also had a new boyfriend who she had sex with, which Heidi described as “absolutely terrible” due to her experiences of sexual abuse. Heidi started moving into a new set of friends external to school who were involved in a White supremacist group, and were from difficult backgrounds. She broke up with her boyfriend which she felt was quite disastrous, partly because they had had a sexual relationship which was very emotionally significant for Heidi. She became more angry and self-abusive, started drinking and smoking cannabis. She was also on medication that made her look “dopey” and she feels she was ostracised to some extent because of this. She began having panic attacks and was put on Diazepam which she began abusing. Her medication was changed very frequently and left her feeling groggy. Heidi was having counselling twice a week but it was not helping.

Heidi had made a plan to kill herself, and was admitted to hospital after her counsellor had asked her if she wanted to die. She was discharged after a week. Counselling continued, and things just got worse. Her friends knew she was suicidal. One day they were all drinking Datura extract and Heidi told her friend that she was going to take so much that she would be hospitalised. After wandering around for several hours, Heidi was picked up by an ambulance and taken to hospital. However, she was treated as a drug user, not as a suicide – no one asked. The police said she was lucky she was not in the cells.

Heidi continued to engage in other forms of self-abuse. Her friends did not consider being suicidal acceptable, but other abuse was, and she began sex-working. At age 18 Heidi had another suicidal phase, during which she planned to hang herself. However, she was concerned about what her body would be like by the time she was found. Soon after this Heidi became pregnant and that was the final turning point. She got another counsellor and committed to working with her. She also felt that sex-working had become emotionally damaging for her, and decided to stop doing it. Until this point, neither counselling nor medication was of any real help to Heidi.

Heidi's strong relationship with her mother was helpful. Heidi goes to church now, which gave her a sense of grounding and purpose. Heidi said she has learnt that things always do get better. She knows people who have killed themselves, and has realised the effect it has on others. "The people who you want to hurt don't care, and the only people who are hurt are those you care about".

Jackie

Jackie was born in 1980 and is a Pakeha/European. When aged about 10, Jackie realised that her family was "screwed up", in part because her father is an alcoholic. Although her father was not physically abusive, he was emotionally cruel. Although she thinks she had probably been depressed for some time, at about the age of 15 Jackie began to get very depressed; she became withdrawn, isolated and started to hate herself. Jackie also indicated that she had been sexually abused, but was unable to speak about this.

An older friend suggested Jackie see her doctor. The doctor gave her a prescription for Prozac, which was of no help. Jackie began to consider committing suicide. She tried cutting herself on her arm to see what it would be like to cut her wrists, because she did not want to fail at a suicide attempt. She discovered that cutting gave her a sense of release of tension. A month or two later Jackie made her first suicide attempt. Although she describes it as a suicide attempt, Jackie said she knew she probably would not die since she took only 5 prescribed headache pills. She felt desperate and did not know what else to do. She was taken to hospital after telling her employer what she had done. Medical treatment was not required and Jackie decided to seek counselling. The hospital called Jackie's parents, who did nothing. They did not talk about what she had done. Jackie thought they did not care.

Six months later Jackie went to a counselling centre – she was cutting frequently at this point. The psychologist she saw did not seem to care and the night after her first appointment she cut more severely than usual and a friend called the Crisis Assessment & Treatment (CAT) Team. Jackie was admitted to a psychiatric ward. She was taken off all medication and was told if she carried on cutting herself she would develop Borderline Personality Disorder. Although she did not really know

what BPD was, this scared her. She was afraid of “turning out like them”. Jackie stayed in the ward for 2 weeks, but it did not help.

A year after the first attempt Jackie made another, this time taking 30 Panadol. She said she did not really want to die, but did not know what else to do. She had been seeing the school guidance counsellor, a psychologist and psychiatrists and had tried several medications, none of which helped. Nobody really seemed to care, and nothing changed. She wanted help, but felt that she was treated as “just attention-seeking”. Six months after the second attempt Jackie began university. Although she was still cutting, Jackie coped through the first semester. In the second semester she began to attend a depression group. It was at this group that Jackie met Linda. Jackie said that Linda was exactly like her, another cutter, attending the same counselling service and feeling suicidal. There was an instant affinity and understanding between the two. A few weeks after meeting Jackie went flatting with Linda. At this time Jackie thought taking an overdose was an acceptable way of trying to get someone to do something to assist her with her depression. Linda had never overdosed, so she took an overdose with Jackie there to call the Crisis Assessment and Treatment (CAT) team. The next day they both overdosed; Jackie said this was a real attempt to die. However, once she had taken the pills Jackie panicked and rang the CAT team before reaching unconsciousness. The CAT team were angry and verbally abusive. Jackie said that that was when she really grasped that she could die; even though she wanted to die, she had thought she would live.

Jackie and Linda’s cutting became competitive; each time Jackie cut, she cut deeper than before. Jackie began to see another psychiatrist, who stopped all her medication. Jackie had been told that there was nothing else that could be done, but this psychiatrist then put her on mood stabilisers and they were very effective. However, following the breakdown of the friendship with Linda, Jackie was feeling so bad there did not seem to be anything she could do since her medication had been increased. At this point Jackie decided it was really time to kill herself and took 180 pills. She says she knew that her survival instinct would take over once she had taken them, but she really did not want to ring anyone; she wanted to die. However, she rang her flatmate, who arranged for an ambulance to come.

While in hospital, a nurse spoke to Jackie about Dialectical Behaviour Therapy²⁸. Jackie said had little faith in the therapy initially, but felt she had no options. She had previously done cognitive behavioural therapy which had helped a little. During cognitive behavioural therapy she was able to stop cutting for a several months, but she said she was not given skills to replace it with, so when something went wrong she would go back to cutting. DBT was different. By this point Jackie really wanted to get better. She thinks DBT would have helped if she had done it earlier, but there were 3 or 4 years when she did not really care what happened to her. Jackie is still on medication, but DBT was 'it', and she felt at the time of the interview that she had 'recovered'. However, some weeks after the initial interview Jackie was experiencing some difficulties, and self-mutilated on two occasions. At the time of writing she was hopeful that this was a temporary setback.

Jane

Jane was born in 1976 and is of European descent. Her father had an unpredictable and explosive temper and could not be reasoned with when angry. As the eldest, Jane felt it was her responsibility to defend her brothers from their father. Jane's mother would sometimes modify Jane's father's behaviour, but at other times would exacerbate it. She describes his behaviour as "an undirected tantrum - like a 3 year old". For example, as a teenager, Jane's father would slap her across the face. Jane feels that physical abuse is easier to cope with than verbal abuse - "words don't leave you, they define you". There were also financial problems for the family, and Jane identified this as a source of stress for her parents, who were competitive with their siblings regarding financial success and possessions.

Jane describes herself as having "always been a geek". She did not fit in at school, and always felt different and unattractive, not a "typical girl". At secondary school she had a large group of acquaintances through the family's church, but still felt 'different'. Although she got some sense of identity from being different, she felt inadequate. She describes herself as scared to be female in case she failed. Jane considered joining the army and cadets, but she was too scared to try. She said her father taught her she was fundamentally inadequate.

²⁸ Discussed in Chapter Two.

Jane's first suicide attempt was at age 8, when she took homeopathic tablets. She knew that one way to kill herself was to take pills, but did not know about the lethality of different ones. She had a suicide plan from about the age of 14, but had injured herself (though not seriously) before that. She always carried a knife and kept a bottle of poison under her bed for years, and took risks such as not looking before crossing the road. She was leaving her life up to fate. The worst stage was while she was aged 13 – 17. She tried drinking carbon tetrachloride but could not keep it down. She tried to cut her wrists several times but could not cut deep enough. She also took drug overdoses but was just left sick and groggy. She did not receive medical attention for any of these attempts. Jane also engaged in superficial cutting, as recently as 1999.

Jane talked of her feelings during her mid-teen years as “grey” and “wanting everything to stop”. Death was a definite goal. She does not believe in an after-life. Jane said that at this time she wanted to sleep forever, “To be no more”, or even better, to have never existed.

Jane decided to become mute when she was 17. She was prescribed anti-depressants at this time, but her mother confiscated them. Within her family this mute period is referred to as ‘when Jane was sick’. Jane decided to stop making any noise as a containment mechanism: “I was afraid of breaking”. This period lasted approximately 9 months.

It has now been approximately 5 years since Jane engaged in any life-threatening behaviour, but she said she still felt suicidal when she was self-mutilating a year prior to the interview. She said she changed because she knew it could be different.

At approximately age 18 Jane realised that her parents were the source of her problems and she consciously decided she was not going to let them “win”. Jane developed a group of friends quite quickly when she began university at 18, including a boyfriend who realised Jane was unhappy and encouraged her to seek counselling. She had lost touch with friends from school, and when she started university she was able to make friends with her new boyfriend's friends. Jane said that she felt like she was starting afresh, and this was an opportunity for reinvention. Her family have not

been involved in her “change”, and they are against counselling. At one point Jane saw a psychiatrist, who subsequently spoke to a relative, breaking confidentiality.

She describes her recovery as a process, not an event. There were catalysts along the way, but it has been a gradual change over a period of five years. She has been on sleeping tablets and anti-depressants and has a friend look after them.

When asked what would have helped her, Jane replied, “Getting out of home – having somewhere to go that was solid and safe”. She describes friends as important but she questions if they would stick around “if you showed them the ugliness ... Some-one trustworthy to talk to, especially a guy. Somebody with mana...an action [from someone], something proactive – someone actually noticing...knowing there’s other people like you.” Reading also provided an escape for Jane.

At the time of the interview, Jane had been off anti-depressants for a year. She said she can usually cope, and knows her triggers and what to do. She said she still “feels the weight” of knives and her sleeping tablets. She doesn’t “want her father to win”. Jane continues to feel a lot of guilt for being weak and inadequate: “it’s something you live with”.

Jen

Jen is a Pakeha/European and was born in 1954. She grew up in a small town, until her parents died, when Jen was 15. Her father died first, and her mother died of “a broken heart” a month later. Jen strongly suspects that her mother committed suicide. A year before her parents’ deaths a neighbour killed himself. Jen described herself as having been hugely affected by this suicide; she spent a lot of time thinking about how he must have been feeling, and about death generally. Jen describes herself as very introspective at this time.

After her parents’ deaths, the Public Trust took over the family’s affairs. Although she had godparents, they largely left matters to the Public Trust. Jen was sent to boarding school, against her wishes. Jen had never been to the city in which the school was situated before, and knew no one there. Before she arrived, the headmistress explained to the other girls that both her parents had recently died,

which had the result that they treated her differently. Jen was very unhappy; she found suddenly being with 150 girls very hard, and she had no control over the most basic daily functions, such as what and when to eat or when to shower. She was unable to express herself, and said “I felt raw, as if I’d been peeled”. She began to harm herself, cutting herself with a razor, and burning herself with the iron. Jen’s relationship with her older sister was strained, and she had no extended family. She felt there was no one left who cared about her. During her holidays, Jen went to stay with her sister, where her sister’s father-in-law sexually molested her. Jen told her sister but was not believed, consequently Jen had to return every holiday.

The headmistress became concerned about Jen, and sent her to see a psychiatrist. This person “Badgered” Jen for details of her sex life. Jen said she knew this approach was completely wrong, but she was powerless. The day before a session with this psychiatrist Jen swallowed all the pills she could find. She went to bed, expecting to die. Instead, she woke up in hospital 3 days later. She had vomited, which aroused the suspicions of staff.

Jen said that at the time of the suicide attempt she felt no one would care. Professionals had not helped her, and, in the case of the psychiatrist, had made things worse. She felt that nothing was in her control except her life itself. Jen did not make another attempt, but did accumulate pills ‘just in case’. Jen said it is hard to say why she did not make another attempt. She was very annoyed when she woke up in hospital, but after a month she felt much better. She was not offered counselling, medication or therapy other than occupational therapy. However, she had the opportunity for a rest, and felt that nothing was expected of her. After the month in hospital Jen returned to school. Her room-mate was the only one who seemed to care. In addition, Jen “was told not to upset the other girls”, which left her feeling that she was a nuisance. She did not receive any other support, and continued to feel alone and uncared for. Although Jen’s sister knows about her suicide attempt, it has never been discussed, and her sister seems embarrassed by it.

Jen said that she has felt suicidal many times since, but she now can recognise the warning signs before she gets deeply depressed, and is able to get help, to talk to someone. At 16, she did not know what to do or how to get help. Jen thinks that now medication such as anti-depressants, would be a good thing as a first step, to get

past the crisis. Jen suggested that this should be combined with counselling, but for counselling to be successful you have to be committed, and it is hard to commit to anything if you are deeply depressed. Jen's 30th birthday was a major turning point. After 18 months of weekly visits to a psychiatrist she was finally able to talk about how she felt. The only other person who knows is Jen's husband. She said she is very aware of social stigma, including in her own head. She is very sensitive to words like 'crazy', even if they are said as a joke. However, Jen said she now sees her suicide attempt as a perfectly logical reaction to an untenable situation. Jen had been depressed for a long time, but the only support offered to her was psychiatry, which proved to not be what was needed.

Jen said that it would have been helpful for her if someone had explained that her feelings of grief and being alone were perfectly normal, especially coupled with the common teenage pressures and biological changes; it was understandable that she felt miserable. Her feeling that no one cared was quite realistic under the circumstances; her life as she knew it had come to an abrupt end. It would also have been useful, Jen thought, if she had had some one to talk to about the sexual abuse. It may also have been helpful if her parents had talked with her about the neighbour's suicide.

Kate

Kate was born in 1952 and grew up on a farm, in a "normal 1950s family". She described her ethnicity as 'New Zealander'. Kate was a very quiet, sensitive child who also had panic attacks. However, she is not aware of anything 'bad' that happened. Due to her anxiety, Kate was taken to see a psychologist for approximately six months when in her early teens, but this did not achieve anything. She was subsequently put on Valium, which also was of limited help. Kate's mother volunteered at a nearby mental hospital. Kate went there with her mother once, and feels this triggered anxiety about herself, she was scared of ending up there.

Kate sources some of her unhappiness to her relationship with her younger sister. Her sister was always told how pretty she was, while Kate never was. As they got older Kate's sister always had boyfriends while Kate did not. Neither intermediate nor high school are sources of fond memories for Kate. Kate's grandmother

committed suicide when Kate was 12. This was a very difficult time for Kate and she chose not to go to the funeral. At the time she felt angry with her grandmother. Kate *found* out this year that her other grandmother had also committed suicide, before Kate was born. Throughout her schooling Kate *suffered* from anxiety and panic attacks. She was occasionally prescribed anti-depressants during these years. Kate began working after leaving school, but was troubled by failed relationships in her early 20s.

Kate made one suicide attempt when aged 22, an overdose of prescribed anti-depressants. Immediately prior to the suicide attempt Kate had been living in another town and going out with a travelling salesman, which she found difficult to cope with, and she got “really down in the dumps”. She was taking anti-depressants, which left her feeling like a zombie in the morning, but she felt worse without them. The day of the overdose, Kate was with her mother, when a neighbour came up to them and asked Kate’s mother how Kate’s sister was (the sister was married with children at this point). She did not ask Kate how she was. Kate felt ignored, and that she was a failure in comparison to her sister. When they got home, Kate took an overdose. She then told her mother, who took her to the doctor’s surgery, then to hospital where Kate’s stomach was pumped. Kate then spent two weeks in a psychiatric ward undergoing group counselling. Kate felt her problems were minor in comparison to the other patients, and that she should have been able to cope. She did not find the experience at all helpful; it simply added to the stigma she felt. Kate’s friends visited her in hospital but they were not particularly helpful. The suicide attempt has never been talked about within Kate’s family.

After she was discharged from the psychiatric ward Kate was referred to an out-patient counsellor. She is unclear about the details now, but feels it had no impact. She then met the man who was to become her husband. “That did more than any anti-depressant.” Kate continued to take anti-depressants some of the time until she married.

Kate said she has since felt as bad as she did at the time of the suicide attempt. She also still gets panic attacks, and has been hospitalised because she felt she could not cope. Kate began counselling when aged about 30, which she found very helpful, especially in regard to information she was given on the physical responses to anxiety

and panic. She could talk about anything and felt understood. Kate's husband did not really understand. Although Kate was very depressed at times, once she was a mother she felt a responsibility towards her children, which prevented another suicide attempt.

Kate said that "age has made her wiser"; she gradually got better over time, and said a turning point was when she accepted that she would have to be on anti-depressants for the rest of her life. She now sees depression as the same as diabetes or a cholesterol problem: an illness that is not her fault, and that can be dealt with through medication. She said there is a terrible stigma about mental illness, and people who cannot understand should realise how lucky they are.

Initially, Kate said there was nothing that any-one could have done to help her with the emotional distress that led to her suicide attempt, but then she added that a good counsellor would have helped. "There are lots of shonky ones that make things worse. I don't believe in some of their airy-fairy ideas". Kate acknowledges that at the time of her suicide attempt she did not have any-one to talk to, and people do not recognise the early signs of depression. "There is no easy answer – it has to come from within you, but I don't know how you get to that. You need to learn how to deal with it." For Kate "dealing with it" includes skills such as relaxation and breathing techniques, exercise, not feeling stigmatised, and recognising the warning signs before things go too far, so she can get help. Kate said anti-depressants are much better than they used to be. Kate felt that "lots of doctors don't have a clue. The worse thing is to be told to 'pull yourself together'".

Lara

Lara is a Pakeha woman who was born in 1970. She said she had "a great mother and a crap father". Lara felt that she did not fit in, from quite a young age. She was repeatedly sexually abused when 8 years old, plus other incidents at different times with different perpetrators. She began to realise that she is a lesbian when 13, and this was quite difficult to deal with. She experienced some depression during her teenage years, and thought about suicide a lot. Lara said that it seems like there was a lot of criticism of her, and she felt she was not good enough. She was always shy and felt inferior; her sexuality added to this.

When aged 23 Lara was diagnosed with a serious medical condition; part of the condition is depression. This led to her losing her job. One of her brothers died 3 months after Lara left work. A relationship of 5 years duration broke up a year after her brother's death, and she had a miscarriage in between her brother's death and the relationship break-up. The combination of all these things gradually led her to thinking about suicide again.

Lara engaged in self-harming behaviour for about a year when she was 23. This consisted of burning her stomach and arm. Lara said there was no particular trigger for this; it was a release of a gradual build up of emotional pain. The physical pain made it easier to cope. She realised it was hard for others to cope with, although "it felt normal for me". Although it was very painful, "the pain didn't worry me at all". Lara said that this self-harming is quite different from suicidal behaviour. She said she just wanted to hurt, to let the internal pain out. Lara never received medical treatment for the burns.

Lara's depression continued to get worse during this time. Lara was hospitalised when she was 24, because she wanted to commit suicide and had taken active steps towards it. She wrote a good-bye letter to her mother, and was preparing to take an overdose when her partner came home and realised the state she was in and called the CAT team. Lara was eventually convinced to be admitted, although she wanted to die.

Prior to the incident that resulted in her hospitalisation, Lara had been on Prozac and seeing a counsellor – the fourth. She was in hospital for 5 days, and saw a psychiatrist after two days. He doubled her dosage of Prozac, and put her on Nortriptylene and 'left her to it'. The psychiatric ward was not a positive experience for Lara. She found some staff unsympathetic and unhelpful about things such as the routines and protocols of the ward. The dosage of Prozac was increased several times which did lift Lara's depression but it left her feeling aggressive and out of control "like another person; I felt like I was losing my mind". Lara's dosage has now been reduced, and it seems to be working well.

Lara's family and friends were shocked by her admission to hospital. Her remaining brother was angry, and only visited her once, but others people were very supportive, and she had visitors every day. Her mother and partner of the time had always tried to be supportive, but were unsure of what to do. Afterwards they were aware of the signs that Lara was going downhill, would monitor her behaviour, and provided practical help such as taking her for a walk. However, Lara has been left with a residual feeling of 'you are a mad person'. She sometimes felt like she was being humoured, and that was hurtful.

When she was released from hospital, Lara was put in touch with a counselling service for visits, and a visiting health nurse, both of which she found helpful. They provided her with some one to talk to who could understand. Lara previously had three unhelpful counsellors, but when she started with a good counsellor she realised how much of an impact the sexual abuse had had. She said she felt like scum, and had a total lack of self-worth.

The first counsellor Lara saw was a psychologist who encouraged her to tell him everything about the abuse she had suffered, despite her not feeling ready to discuss it. His judgement of the abuse was that it was "just kids playing". After seeing him, Lara was so upset she vomited. The second counsellor Lara saw she persevered with for a year, but no progress was made – she did not really get to the crux of anything. The third counsellor was a lesbian, whom Lara thought she would be able to relate to. However, she minimised Lara's experiences, commenting that "others have been through much worse". Lara said these counsellors always made her feel that they were the professionals and knew best, whereas she was silly, weak, and "born feeling blue". The fourth (and last) counsellor was the one Lara was seeing before she was admitted to hospital, and she continued to see him for another one and a half years afterwards. With him, everything 'clicked', although it took a long time for Lara to believe in him and develop trust.

Appropriate medication has been very important for Lara. Lara thinks Prozac has exacerbated some things. For example, one side effect is that she gets strong food cravings, which have resulted in weight gain, a source of unhappiness in itself.

Louise

Louise grew up with both parents. She is Maori, and was born in 1980. Louise identified a number of things that contributed to her suicide attempts. Louise's relationship with her father was troubled. He treated Louise's mother badly, occasionally abusively. He also was verbally and occasionally physically abusive to Louise. Towards the end of the fourth form, Louise started drinking and smoking marijuana. This was in conflict with her Christian beliefs. She also lost her virginity during the fourth/fifth form summer holidays. Although she said she was not raped, she was very upset at the time, and she made her first suicide attempt that night. This was made worse because Louise was the topic of gossip afterwards. Louise was finding Christianity increasingly incompatible with her weekend behaviour, so she gave it up in the fifth form. Louise said she never really liked herself during this period. She was concerned about her weight (her father called her fat), and despite discomfort with her weekend behaviour, she felt she was missing out if she did not go out drinking.

Louise describes fifth and sixth forms as "a disaster". She was taking drugs frequently and her parents split up; although their relationship was upsetting, Louise would rather have had her parents together. . A friend of Louise's committed suicide, which she thinks was an important influence. Although her mother spoke to her and made her promise that she would never commit suicide, she was thinking "why not?". In sixth form Louise was not able choose her subjects because she was in a top-stream class. Instead, she had to take science-based subjects, which she did not enjoy or understand. She failed these courses, which was difficult for her because she was used to succeeding academically, so she lost motivation. Previously she had liked learning. Nothing seemed to be going right, and Louise felt that she had nothing to look forward to, and did not like herself. Louise and her friends encouraged each other to miss school, and to take drugs before exams. Louise thinks her distress should have been obvious, but her mother just seemed to think it was a temporary phase.

Apart from these stressors, there was no particular trigger to Louise's three suicide attempts subsequent to the night she lost her virginity. "It just happened", although Louise mentions one occasion she had made a real effort to lose weight, and no one noticed, even when she asked them, which left her feeling like a failure.

Louise twice took overdoses with a friend. On these occasions they were both drunk, and had got into a pattern of talking about their problems and depressing each other. They took overdoses of Panadol, and subsequently vomited. Neither Louise nor her friend had medical attention. On another occasion Louise and her friend cut their wrists. Another friend told the school counsellor what had happened, and the school counsellor referred Louise and her friend to an independent counsellor. The session with the counsellor “was a disaster”. The counsellor had recently lost her own daughter to suicide and was very angry with Louise and her friend. The session ended with all three in tears. There was no follow-up.

Louise said that she thought that if she harmed herself some-one would help her, but no one knew except some friends. The only person who ever talked about the suicidal behaviour was the friend who was actively involved in it; other friends never brought it up. Louise’s family do not know about any of her self-harming behaviour.

Louise began self-mutilating in 1999. She was angry because her relationships were not going well and cutting made her feel better for a while: it hurt, so it was a release of anger. It felt like something strong to do. Although she “knew it was kind of stupid. It was a clear decision to do it, when I felt kind of powerless”.

Louise said she does not really know why she stopped the suicidal behaviour; it was a combination of little things, and feeling better about herself. However, she has not made a conscious decision not to do it again. Louise got another boyfriend which helped, it was the first time she had been in love “and it was wonderful”. He also did not like drugs, so she stopped taking them. Things “just got better”. Louise’s parents got back together, and their relationship was much happier. She started making plans to go to university, and made new friends.

Louise said she still thinks about suicide sometimes, but she does not think she will try it again. Louise said she thinks about what her mother would do if she did it again. She has been to the counsellors at university, which has helped. Louise can now think about what she has learned, and recognises that her feelings of depression will pass.

Lucy

Lucy was born in 1975 and is a Pakeha. Lucy attended boarding school from ages 13 to 16, at which time she was asked to leave. She describes this as being the result of a personality conflict with a senior staff member; she was rebellious, but not 'bad'. She had done well while at boarding school, without really trying. When she changed school she tried hard, but failed, so she quit trying, and left school a year later.

Lucy started working for a relative, which she found difficult, as other staff appeared to think she only had the job through nepotism. This was made worse because Lucy was living alone, in her family home while her parents and sister were away. She knew few people in the town she was working in, and she was shy. She also went on the contraceptive pill for medical reasons, which made her very anxious and depressed. Lucy had had no problems with depression before this.

Lucy's sister returned home, but spent little time with Lucy, instead taking up with Lucy's best friend, leaving Lucy feeling rejected and increasing her sense of isolation. Lucy also experienced several physical ailments at this time. Lucy began to feel that she would be doing everyone a favour if she killed herself, and felt that people would soon forget about her. She said she was full of self-hatred. She could not talk to any one because she could not make sense of it herself, and was terrified of being rejected. Lucy knew someone who had been in hospital for depression, and felt that people think depressed people are weak. Lucy could not see a solution other than suicide. Lucy felt that she would be doing everyone a favour if she were no longer around. She was tired of crying every day and felt the only reason she was still alive were the "lame excuses" she kept making to herself for why she should live.

Lucy planned in detail how she would kill herself. She had picked a spot where no one close to her would find her accidentally, where she was unlikely to be disturbed, and started to put her suicide plan into action. She gathered up the necessary items: she planned to cut her wrists, and it was during the stage of writing the suicide note that her sister unexpectedly came home. Lucy is certain she would be dead if her sister had not found her.

Lucy's sister realised what she was planning, which prevented her from continuing that night. The next day Lucy's sister made her go to the doctor. The doctor told Lucy to stop taking the pill, and if she was not better in a week, she would be put on anti-depressants. At this point Lucy could not explain her depression; she felt ashamed and embarrassed. The family doctor was hard to talk to. Lucy had gone to see a female doctor earlier in an effort to get help, but she could not bring herself to talk to her; she seemed very clinical and unapproachable. Lucy said she "felt like a head-case" when the family doctor suggested anti-depressants. She decided to try to stick it out for a week and see what happened. At the time it did not seem to make sense that a little pill could make her hate herself and believe everyone else hated her. However, a week later she was feeling better. Lucy never discussed it with her doctor again. A week later Lucy's parents came home.

Everyone around her started making an effort, and things started to get better. Because people were making an effort, Lucy wanted to try too. It was never discussed with her parents in any detail; she felt they would just be angry. "My family's quite weird – we don't really talk about things". Lucy was able to talk to her sister although they had never been particularly close, and a friend's mother, Judy. Judy was very easy to talk to and non-judgemental. Lucy had not previously been very close to Judy, but they became close, and she also became close to Judy's mother, Kylie, whose support meant a lot as Lucy had at first been quite intimidated by her. Lucy's relationship with her sister did not change much, but her sister seemed more aware of her actions. People were being nice, honest and genuine, which was important, as Lucy did not want pity; she just needed genuinely nice people around. Lucy thinks that if she had not had Judy and Kylie to talk to it would have taken her a lot longer to recover. They did not judge her, just listened to her.

Maree

Maree was born in 1970 and is a Pakeha. She made two suicide attempts, when aged 16 and 23. Maree's mother had been suicidal when Maree was growing up and had attempted suicide at least once. Maree's older brother sexually abused her when she was ten. The family were also very religious so Maree always felt 'different' from her school-mates and that she did not belong, although when she left the church at 16

she had a period of feeling that she did not belong with people she knew from church, or all her school-mates. Her parents separated when Maree was 16.

Maree found it difficult to articulate exactly why she attempted suicide at 16 “I was just really unhappy”. It appears that it was a combination of her parents’ separation and her background of social isolation and abuse. She took an overdose of aspirin and subsequently had her stomach pumped. Maree visited the hospital psychiatrist and was then referred to her family doctor who was also a counsellor and psychodramatist. The hospital psychiatrist was most unhelpful; Maree felt like he really did not care so she did not talk to him about anything. The family doctor was of more help, but Maree continued to experience periods of depression. She was bulimic from her mid-teens to early twenties, and also had periods of drinking heavily. Maree made a commitment to “get on top of it [bulimia]” when she became pregnant at 21.

At 23, Maree had recently broken up with her husband, had a two year old child and was on the DPB, not liking herself, thinking she was unlovable, not being able to get control and hating herself for her behaviour. Maree attempted to cut wrists with a razor blade and knife. She went onto anti-depressants and her parents cared for Maree and her son for six months after the second suicide attempt. Between the ages of 23 and 25 Maree often sat in the shower with razor blade, and had another period of bulimia between the ages of 25 to about 28.

Maree received counselling on and off over a period of 12 years, with several counsellors. Some of her closest friends were themselves suicidal or had eating disorders so in a way they used to care for each other. Her family of origin ended up in several family counselling sessions, not just as a result of Maree’s behaviour but also because of several issues in the family, particularly sexual abuse issues involving other family members. Maree finds it difficult to remember exactly what was said; she used to cry a lot and quite often it was that they just listened. After she split up with her husband, one of her counsellors said that she did not have to stop loving him. That was a turning point for her because she realised she did not have to try to change her feelings.

Maree's mother became a counsellor and often she would listen and then reflect back what Maree said so that she could hear herself and work through issues that way. Also she kept telling Maree that she loved her. There was a time when she became angry with Maree and said, "I've had enough of this. I'm sick of it and I'm not going to put up with it any more". That was helpful because Maree realised she had to take responsibility for herself and people would not always be there to make her feel better. She had to do it herself. Both of the counsellors that Maree considers made a difference for her were firm, making her take responsibility.

Maree's family were very helpful. Her mother had been involved in therapy herself by the time Maree engaged in the suicidal behaviour and was working through a lot of her own issues so she was "just amazing". Maree's father was less helpful in that regard but certainly tried to make her feel loved and supported and not judged.

Maree has also found support in her community through the social structures that she set up for herself such as involving herself with community organisations, getting to know other single parent families, often looking after each other's children. Some of the people she knew through community groups had also engaged in similar behaviour. Maree said that these people have also contributed to her recovery in terms of providing a sense of being understood and encouraging each other.

Maree believes strong social support is critical. She can see now that one of the things that happened for her when she was 16 was that she left a church structure that had been her only means of support outside of her family. When her family structure broke down and she did not have or want the church there was nothing else there. It would have been good to have more of that support in school; when she looks back her grades had been dropping and as it was a small school the teachers knew what was going on in her family. No one ever approached her to ask how she was but she does remember her name being called out to attend a 'special' study group. Maree did not know why but she thinks now it may have been an attempt to support her in some way. At the time she declined to go to it and was really upset to be singled out because it just made her think there was something wrong.

Naomi

Naomi is a Pakeha/European and was born in 1975 and lived with her parents until aged eight. At that time, her parents separated and over the next two years she lived in several towns around the country, usually with her mother. Her mother remarried when Naomi was 10. Naomi went to boarding school from the age of 12 onwards.

Naomi was sexually abused by her stepfather, as a 10 year old. Naomi told her mother about the abuse, but was not believed. Naomi was also physically abused by her step-father, and her mother always took her step-father's side. It was a mutual decision for Naomi to go boarding, "although it felt like it was the only alternative". When boarding Naomi did well as she was able to block off her feelings at that time, although she did take "an attention-seeking overdose" in Form Three. Naomi became anorexic shortly after leaving school and in turn began self-mutilation (cutting). The trigger for this was comments about her weight from a tertiary teacher, against a background of depression and low self-confidence. She said this was an expression of self-hate.

When she was 18 Naomi made friends with a family through her church and eventually moved in with them. However, Naomi's relationship with her 'foster mother' deteriorated, leading to the family asking Naomi to live elsewhere. At around the same time, Naomi's mother told her that she now did believe her about the sexual abuse. Up until that time, Naomi had only partially confided in her mother. At this point, Naomi told her mother everything. Naomi's mother responded by telling others that Naomi "was making up more stories". Naomi's father also said that Naomi was mentally unwell. At this point Naomi became very depressed and she made four or five suicide attempts (overdoses). Naomi was hospitalised on two or three occasions. She saw the duty psychiatrist on each occasion, but at that point she wanted to get the session over with as quickly as possible so that she could go home. The fact that she had to see a different psychiatrist on each occasion was not helpful as she would have to tell her story each time, which was upsetting in itself.

Naomi said the most important factor was the lack of a relationship with her mother. Although the sexual abuse was also an important factor, and Naomi probably would not have become estranged from her mother if the abuse had not occurred, the

limited, superficial mother-daughter relationship, she feels, has had more long-term impact. Being forced to leave the new family she lived with later was like leaving her mother all over again.

Naomi has seen a number of mental health professionals including a school counsellor when boarding, a counsellor with regards to her anorexia and a psychologist referred by the pastor of her church. Naomi has also had contact with members of the CAT team with mixed results. Naomi mentioned her surprise at how long it took before anyone restricted her medication. Eventually her doctor changed her to weekly prescriptions so she could not use them to overdose, but this took quite some time. Naomi's doctor has been helpful. However, Naomi's psychologist contacted the doctor, suggesting she put restrictions on Naomi's telephone calls to her. As a result, after an overdose both the psychologist and the doctor refused to talk to Naomi, leaving her feeling abandoned. Naomi did not find antidepressants very helpful, and she discussed a number of alternatives with her doctor, at one point asking for electro-convulsive therapy, and hospital admission, both of which her doctor refused. Naomi felt she needed 24 hour care. Naomi also had misunderstandings with the psychologist about boundaries, such as calling the psychologist at home. This eventually led to the psychologist refusing to see her again. Naomi said the counsellors she had seen previously were not at all helpful. Naomi now sees another psychologist and is able to talk things through.

Naomi said that being "forced" to live by herself has been a turning point. If she tried to commit suicide, no one would be around to find her. Although she was serious when taking the overdoses, and she did really want to die, after she had actually swallowed the pills she would change her mind. Naomi said the desire to die really only left after two of years of living by herself. During that two year period, she wanted to die, but did not act on it. Instead, she turned to cutting to cope. With cutting, Naomi is able to focus on the physical pain, instead of the emotional. She feels this a less damaging behaviour, as it does not hurt any-one else and there is no long-term effect. It also lasts longer, as she likes to watch the cuts heal which takes two or three weeks. Naomi has been trying to stop cutting and use other ways of dealing with her emotions, and counselling with her current psychologist has been useful. She has had periods of several months over the year prior to the interview when she has not cut, and feels that she is making progress.

Patti

Patti was born in 1968. She is a Pakeha woman. She began self-harming at age 13 and made suicide attempts between the ages of 23 and 26.

Patti suffered the trauma of being tortured by a neighbour who was mentally unstable when she was aged about seven. She was also sexually abused by a family member between the ages of five and eleven. There were a number of sources of stress for the family. When she was twelve Patti's brother was seriously injured in a car accident and there was a long rehabilitation process. Her grandmother suffered from depression and died when Patti was thirteen and her grandfather died when she was eleven. There was a lot of conflict between her parents and her mother and sister, and differing religious beliefs within the family also contributed. These stressors, coupled with low self esteem, feeling unable to meet her own and others' expectations, alcohol and drug abuse and anxiety led to Patti's self-harming behaviour.

Patti's self-harm started out with minor cutting and bruising, taking risks, taking extra medication and mixing alcohol with drugs, probably once a week to once a fortnight. The first suicide attempt was an overdose; she was hospitalised as a result and had her stomach pumped. The second attempt was by gassing herself in a car.

Patti's family initially denied the fact that there was anything wrong. Her family seemed ashamed of her behaviour and seemed to deal with this by ignoring it. It was not until she got married that Patti's husband and his family tried to get her help. Her husband's family were very upset and confused. Friends were very supportive and encouraging.

Patti has seen many counsellors. She started counselling at 24, in the mental health system as well as through a drug treatment programme. Hospitalisation was unhelpful and some medications made her worse. Some people with "quick fix" ideas, and others relying solely on medication were most unhelpful. Cognitive therapy and one to one counselling was beneficial, and Patti continued with this for several years. A belief in God also helped her have faith that things would get better. Patti said it was the combination of support and encouragement from her husband and his family, and friends, combined with therapy and counselling with a therapist

she could trust that have enabled her to recover from the depression and anxiety that lead to her self-harming.

Richelle

Richelle was born in 1980 and is European. Richelle's mother had what Richelle describes as 'a one-person cult'; this 'disciple' lived with the family for several of Richelle's teenage years. There was also family involvement in a cult. Richelle's parents divorced when she was about 15, but from the age of 12 or 13 her parents' boyfriends and girlfriends lived with the family also. Richelle describes her life with her parents as being punctuated by conflict. Richelle is a survivor of sexual, emotional and physical abuse. Her father and her mother's boyfriend perpetrated the sexual abuse. Richelle described her mother as "over-bearing, manipulative and very controlling". Her mother has threatened suicide several times.

Richelle and her siblings were home-schooled and kept socially isolated; although she was allowed music lessons from the age of 14, her mother always accompanied her to lessons. Richelle was not allowed to talk to the teacher more than was necessary, on the threat of the lessons being cancelled. Richelle said that this created a pattern of not being able to speak up. Until she commenced music lessons Richelle and her siblings had no social contact outside the family.

Richelle describes her parents killing the disciple's baby when Richelle was aged approximately 15. The baby was fathered by Richelle's father. The coroner decided the baby died as a cot death, but Richelle remembers her parents smothering the baby on several occasions when it was crying. On the last occasion, Richelle was the person to find the baby, dead. This was extremely distressing for Richelle.

Since leaving home at 18 Richelle has spent some time living with foster parents. She also has another set of 'foster parents' whom she only lived with very briefly, but with whom she maintains a close relationship.

Richelle's first hospital admission was at age 18 for a suicide attempt, by way of overdose. She has been hospitalised for all her suicide attempts (approximately 13), which include several overdoses and two hangings. She was clinically dead on one occasion. She said that being in hospital gave her ideas about other methods, and

about self-mutilating. She said that in some suicide attempts she did not want to die, and did it where she would be found. The most serious attempt was hanging herself after being 'out of it' for 2 weeks. She reckons she wanted to die 99.9% - "it's the other .1% that makes my life hell". She said most attempts were not completely serious in terms of intent; for instance, she would be too scared to take enough pills to definitely kill her, leaving it up to fate, although she describes ending up in hospital, being annoyed to wake up. There were also some overdoses that were not proper attempts. "Life was so unbearable that the promise of just being unconscious for a couple of hours or days was enough".

Richelle began cutting a couple of months after her first hospital admission. She met a cutter there and tried it, and found it helped. She had had eating problems prior to this. She did not need stitches for her cuts until after she started university and met some other self-mutilators at a support group on campus. "That also coincided with having a new shrink ... he wouldn't commit me against my will so although in a way that's what I wanted it also increased my tension and stress in terms of should I kill myself or not". She describes finding it physically difficult to cut deep at first; it was something she had to learn how to do. At the beginning of her cutting career, her cuts were labelled as 'not serious' by medical staff, but they were serious to her, from an emotional/mental point of view, providing a sense of relief. Richelle describes cutting herself as a means of self-expression, stress and tension relief. She said it is not any different from smoking or drinking except that it is less socially acceptable. When she was cutting, Richelle was doing it every day. At one point Richelle was ringing the CAT (Crisis Assessment and Treatment) team every day, in a feeling of constant crisis. Cutting was a means of getting help, but it "became a big hole". Richelle developed a tolerance to cutting; the pain of cutting was "in the background". Richelle described cutting as being very different to a suicide attempt.

Richelle said it is hard to know what has changed. She cannot pinpoint anything specific. Richelle has extensive experience of counselling and therapy. She has been committed to psychiatric units on several occasions, at one time for a year. "I found it too hard to ask to be admitted when I was suicidal and subsequently when I was feeling better, I asked staff to admit me against my will when I was suicidal. Some staff did that but generally that didn't happen ... that made things very hard as far as keeping myself safe. As much as I wanted to die I also didn't want to but...being

alive was too hard”. Richelle also used Lifeline, and a warden at the hall of residence in which Richelle was living was also a counsellor. Richelle developed her own safety plan, similar to an asthma *management* plan: different colours represented different feelings and actions. She was able to use this as a means of communicating her feelings to people, “because it was too hard to say I felt suicidal or like cutting. Even saying the corresponding colour was hard though”. She also utilised the CAT Team, to initiate help. At first they responded immediately and tried hard to help her, but after attending her several times they refused to continue to come out. Richelle has attended a self-mutilator’s support group, but did not find it to be of much help. Indeed, Richelle spoke of contagion within the group; if one cut herself it ‘encouraged’ others to cut. Richelle does not think counselling has had much of an impact; in fact, counselling sessions with her first mental health worker (who did CBT) often prompted a suicide attempt.

Richelle’s foster parents give her lots of attention and love, but it was not enough. She needed something more dramatic; an ambulance, hospital. Her foster families have provided on-going care, in contrast to her previous experience. Although one of her foster mothers is a counsellor, Richelle is not able to talk about her cutting and suicide attempts with her. With the other foster mother she is able to talk, and finds this to be a great outlet.

After she left home, Richelle laid a complaint of rape against her father. Although he was convicted and is serving a prison sentence, he continues to maintain that he is innocent, so his conviction has not provided the sense of justice that she had hoped for.

Richelle said that at some point she just stopped needing that attention. Feelings of wanting to cut or over-exercise can still be triggered by her parents, almost always accompanied by an instant recurring of needing attention. Richelle deals with this by going to the gym and exhausting herself. She is now aware that the feeling will only last a couple of days, so she “just tries to live through it”.

Rhonda

Rhonda was born in 1968, and is Pakeha. Rhonda felt no one except her younger brother loved her in her family; her mother was cruel and abusive to her as a child and she suffered depression because of this. Her older brother sexually abused her, starting at age three.

Rhonda started to feel suicidal from the age of six; she remembers curling up on the bed and hoping she would not wake up. Rhonda said she was a chronically traumatised child who was dissociative. Rhonda developed an eating disorder when in her early teens. She hated herself and never thought she was good enough. The abuse contributed to this self-hatred. She began cutting and abusing substances when she left home in her late teens and was diagnosed with posttraumatic stress disorder and multiple personality disorder, at which time the feelings of crisis increased. Although Rhonda is a lesbian, she said that this was never much of a problem for her.

Rhonda began her self-harming behaviour with cutting when in her teens. However she started to get her sense of pain back so she stopped cutting and began abusing drugs. They numbed the pain and provided a distraction.

Rhonda's first suicide attempt was at the age of 21 after relationship problems. She took Panadol and no treatment was received. The second attempt was after casual drug taking. Rhonda did not remember the details. The third and last attempt was in 1998 when she was 30 and she overdosed and nearly died. She decided after this that if she could not die she would have to live. The impact of the final attempt was enormous on her family because her secret was out but Rhonda said it was a relief not to have to conceal it anymore.

Rhonda has had contact with counsellors and the CAT team intermittently since the age of 15. After the last attempt Rhonda got an effective management plan with the CAT team. This was helpful although it required a big commitment from Rhonda. This was the turning point. Some friends were helpful and some were not; she stopped seeing those that were not. Rhonda's family initially were shocked but were very supportive. Her parents realised they had to accept her as she was or not have her at all.

Robyn

Robyn is a Pakeha woman, born in 1965. She describes her early childhood as quite happy; she was extroverted, with lots of friends. However, her father was a heavy drinker. Her parents' marriage was noticeably difficult by the time Robyn was 10, and her father spent some time living elsewhere. During this time Robyn's mother was having an affair. When Robyn was aged 12, her mother suddenly packed up the family to go to live with her lover. They packed and left in under two hours. Robyn describes this as dramatic and traumatic.

From this point, life got rapidly worse. Her step-father was transferred, taking the family away from their extended family, to whom Robyn had been close. After her mother and step-father's marriage, Robyn's step-father became abusive: Robyn spent the next six years in fear. Robyn's mother took them to Refuges on several occasions, but they always went back. Robyn suspects she was sexually abused, but she has no specific memories of abuse. She was very sexually aware at a young age, and cannot account for this. She felt very insecure when alone with men when younger, and says she was extremely modest, sleeping with her legs, crossed for example.

During her early teens Robyn used to think about killing herself or her step-father. Robyn mentions that she has often wished she was dead. Robyn felt ashamed about her home life. She thinks that things would have been better if she had had the choice of living with her father, but she had no control over what was happening at the time.

Robyn left school at 16 so that she could save some money to leave home, but she was kicked out by her step-father. A week later her step-father asked Robyn if she had called her father about what was happening at home. Robyn said that she had, and the step-father said that her father had died and implied that Robyn had caused it. Although every-one flew to the funeral a week later everyone was expected to carry on as if nothing had happened.

Shortly after this, Robyn entered into an unhealthy relationship. There was some "minor physical abuse" and he was very mentally abusive and took drugs, with which

Robyn also became involved. They moved to another part of the country. Robyn had no one else she was close to at this time, and no money, as everything was going into establishing a marijuana plantation. By this time Robyn was 18 and her relationship was continuing to deteriorate; Robyn was expected to remain under the control of her boyfriend. She had no friends of her own. On the day of the suicide attempt Robyn had gone to see some friends of her boyfriend's who then went out without her, leaving her feeling completely friendless. She went to the doctor because she knew she needed some help. She explained how she was feeling and she was given some sleeping pills, so she took them all. Just before she became unconscious she panicked and telephoned for an ambulance, and was taken to hospital where her stomach was pumped. Hospital staff were unsympathetic and treated Robyn as if she was wasting their time. She was not given a referral to support services, but she was told that the police might want to interview her, and that she would have to pay for the ambulance. Robyn remained in hospital for five days, and was released on the condition that she return to her family. In the interim she was released into her boyfriend's 'care'. He rang her parents and told them she was "nuts", and she was flown down to them.

By this time Robyn's parents were feeling guilty and organised a social worker for her. The social worker organised a job for her, which she enjoyed. She did not talk to any-one about her suicide attempt because she had no one to confide in, plus she was afraid of the stigma, and had developed a pattern of hiding her feelings. Her parents' doctor put her on anti-depressants that she did not take for long due to the side-effects. Her boy-friend arrived and wooed her back. Robyn still felt suicidal at this time; she does not know why she did not make another attempt. However, she had gathered some strength and got another job. Through this job she made new friends who were not into the drug scene and so was able to maintain some independence, and split up with her boyfriend.

This job seems to have been important in Robyn's recovery, because it allowed her to develop a new social circle independent of her boy-friend. Some of her work-mates "mothered" her, giving her affection and support, and Robyn noted that they are probably the reason why she did not make another attempt. She did not talk about what had happened to her, but her work-mates realised she was in need of some nurturing. When she looks back, Robyn thinks counselling after her suicide

attempt may have been helpful, but she did not know how to access it. She also thinks she may not have been ready for counselling.

Sue

Sue is part-Maori and was born in 1978 in a small northland town. Sue's parents were divorced when she was two years old, and she lived partly with her grandparents and partly with her mother from that time on. Sue said that the biggest issue she has had to deal with is a physical disability. Sue was also physically abused by her mother from a young age until she left town at 17, and sexually abused by one of her mother's boyfriends for 8 years. Her mother does not seem to have been aware of the sexual abuse, and Sue received no support around the abuse. Sue said the combination of these factors left her with no self-esteem, until she moved to the city to live with an aunt. Sue now has no relationship with her mother.

Sue has cut herself on many occasions, on her arms, stomach and hip, since the age of 15. Sue said that the minor cuts were not serious suicide attempts, but the result of having no way of expressing her anger and frustration. However she has twice had to have stitches, and was taken to hospital by ambulance, when aged 18 and 20; these were serious suicide attempts. Sue said the first attempt was due to depression about her relationship with her mother: they had not spoken for a year. Sue was out of hospital in a few hours and saw a psychiatrist who felt no follow-up was required. At 20, Sue was not dealing with her disability and the issues surrounding it; for example strangers in the street have insulted her. As a result of this second attempt she was admitted due to blood loss. Sue told a psychiatrist about being sexually abused and she was referred to a counselling centre. Sue's aunt was called by the hospital, against Sue's wishes. This aunt told the rest of Sue's family, who had a hui about it. At a second hui, after Sue was discharged, the family asked why Sue did it, and what they could do to support her. The family decided to deal with it within the family "in the Maori way". The family did get a report from the psychiatrist but it did not seem to contain any useful advice. Sue said the family did help to a degree, but they did not really listen. There was too much advice and not enough listening. They tried to help, but they did not really know what to do. Sue's best friend confronted her after she was discharged, and told her she was worried and upset with her. Sue has now made a promise to her best friend that she will not attempt suicide

again. However Sue also took an overdose in 1999. She said there was no particular incident that sparked the suicide attempt, more an overall build-up of depression. The only effect was feeling very sick and tired; Sue's aunt noticed she was sick and took her to the doctor, who assumed she had come down with a virus. Sue did not tell any-one what had happened.

Sue spent eight months in counselling with her first counsellor. She found her counsellor, Sarah, to be "really good". She was able to build up trust with her, as Sarah talked about her own past. On one occasion Sarah cried with Sue when Sue was upset about the abuse, and Sue sees this emotional connection as demonstrating that she was cared for. Sue now sees a counsellor from a disability service as well. They started working on issues to do with her disability, then began working on the abuse.

Sue received a great deal of support from friends. They were more direct than her family and Sue was able to talk about how hurt she was. Sue said the most important thing is to have people around who will really listen. Sue also got a sense of control when she testified against her abuser in court. She feels that he had taken her power away, but he is now in jail. The fact that she confronted him and he was convicted was a great boost to Sue's self-esteem.

Sue said if she was able to change anything, it would be to have spoken out about the abuse when it was occurring, and to have had some-one to go to when she was suicidal. She did not feel she had anyone around her at the time who was approachable, and her family did not see what was happening.

Tracey

Tracey was born in 1973. She is a Pakeha. Her parents split up when she was seven, and she spent the next two years living with her father, having very little contact with her mother.

Her maternal grandfather sexually abused Tracey until he died when she was 11. Tracey's earliest memory of the abuse is at age seven, but since talking with her mother she thinks that it probably started at age four, because of a sudden change in

her behaviour. She did not tell any-one until she was 16, as she was afraid no one would believe her. At 16 she told her step-father that she had been abused, and while at school she had told a friend; this friend betrayed Tracey by telling other people. She did not receive any help in dealing with the abuse at this time. She felt detached while at school, and was uncomfortable with affection. Tracey felt that a great weight had been lifted from her when her grandfather died. However, dealing with the long-term effects of the abuse was not that simple for her.

When Tracey left home (at 16) she entered an abusive relationship, which lasted until she was 21. Tracey said she felt desperate for love. The end of this relationship marked the beginning of a downward spiral for Tracey; she was left with few friends, as most of them believed her ex-partner when he denied that he had abused Tracey. Tracey saw her doctor in regards to her depression, and was referred for counselling, but she did not go as she did not feel ready, and she did not want any-one to know about the sexual abuse.

When aged about 23, Tracey was put on anti-depressants. These did help at first, but she developed a tolerance to them. She increased her dosage until she was sleeping for 14 to 16 hours per night. The overdose occurred when Tracey was drunk and had a fight with a friend who said "we'd probably all be better off without you". Tracey ran home and took an overdose of her anti-depressants. She said that she felt like no one cared about her, so why should she care about any-one else. Shortly afterwards, when she was feeling groggy, Tracey rang a friend who came around and put Tracey to bed, then left. Some time later another friend telephoned and realised something was wrong, so came to Tracey's house and broke in. Tracey was then taken to hospital. She woke up in hospital 24 hours later. She has been told that the only reason she survived was because she lying on her stomach, so did not choke. Tracey stayed in hospital for two days, under suicide-watch. She was referred to a counselling service by staff. This was the only purposely self-injurious behaviour that Tracey has engaged in.

Tracey said she just wanted to be out of the situation she was in. She has never considered making another suicide attempt, and the one she did make was unplanned. She said she really regrets the impact her suicide attempt had on her

mother who felt responsible. Tracey later found out that her mother and her aunt had also been abused by Tracey's grandfather, and that he had, himself, been abused.

After her suicide attempt, Tracey's mother and step-father were "brilliant"; they were always available for her and would take her to counselling and support her in many ways. Tracey said she has an unbreakable bond with her mother, and can now talk about the abuse because they have both been through it; she says her mother feels some guilt, though. Tracey recognises that her grandfather is dead so cannot abuse anyone else, and this is important to her. Her father did not know what to do, and "freaked out". He feels responsible, as he was the one who left Tracey with her grandfather when he went to work. He went to anger and stress management classes to deal with his anger towards Tracey's grandfather, and his self-directed anger and guilt. Tracey's brother stopped speaking to her because he was close to their grandparents and refused to believe Tracey had been abused.

Only one friend remained close to Tracey, but she was very supportive and made herself available for Tracey to talk to. After the suicide attempt she confronted Tracey, saying that Tracey had scared her, and that she must never do it again. Tracey very much wants to be a mother, and knew she could not be a good mother if she did not get over the abuse. Tracey decided she was not going to let the abuse ruin her life. Helping with her friend's baby helped Tracey get over the abuse: she had a fear that people would think that she would sexually abuse children, and she realised that this was not so. She is now at a stage where she can talk about her experiences. She no longer has the terrible nightmares that plagued her for years.

Tracey has little contact with other friends from that time. It feels awkward if she sees them; they stopped making contact with her after the suicide attempt. She would walk into the pub and hear people whispering about her. The people she works with are very supportive. She had to face them after her suicide attempt, but no one at work judges her.

Trisha

Trisha was born in 1967, and is a Pakeha. Trisha's mother killed herself and Trisha's younger sister when Trisha was 14. Trisha is a survivor of incest, perpetrated by her

father after Trisha's mother died. The family was socially isolated, as the extended family all lived in another part of the country, and even before her mother's death, the family had few visitors. Trisha's father began drinking and Trisha was left with no one she could trust.

Trisha began truanting and spending time on the streets; she had no skills to deal with her mother's suicide and her father's abuse. Trisha would make herself absent whenever her father was home. Trisha would spend hours at night out walking, and would barter sex for a bed for the night. Trisha was afraid that her little brother would be put in a foster home, so that was a reason she did not seek outside help. "I really didn't know who to go to for help without causing all sorts of family trauma when we had all been through so much". In addition, what had happened was too terrible for Trisha to put into words at that point. She saw the family doctor, but he questioned the accuracy of what Trisha was saying, which seems to have been quite devastating for Trisha. It took her last drop of courage to tell him, and then she was not believed. Trisha left home shortly after this, at the age of 16.

At the age of 14 Trisha began self-mutilating. She said she did not really feel the pain when she did it. It did feel intensely sensual and a beautiful release of pressure. "I felt peaceful afterwards" but "it was bloody sore when it was healing", so she did not do it often. She describes feeling mesmerised by the knife and the blood, feeling that she was getting a slice of power back. Trisha also frequently engaged in risk-taking behaviour, such as walking down the middle of the road at night. She began taking drugs and drinking. When aged about 16, Trisha took a "semi-serious" overdose of alcohol and hay-fever medication, several times. She also made two deliberate suicide attempts, overdoses, at about the age of 15 or 16. On one occasion her father walked in, resulting in shouting and name-calling. He did not get help. On the other occasion Trisha slept for three days; no one checked on her. Trisha describes being very distraught when she woke up, because she was not dead and because no one cared. At this point Trisha did not attempt to get help because she did not know of anywhere to go other than a school counsellor, the police or a GP, none of which felt acceptable she felt that she was of no value. She "couldn't even get that [suicide] right, and nobody noticed or cared'.

Trisha saw a counsellor in later years, but this was a bit of a blur due to the misery she was in and her drug use. She eventually had a “nervous breakdown”, shortly after having a miscarriage. Her work supervisor came to her house, as she had missed work, and told her to go to the doctor. Trisha was sent to hospital, which she describes as “bliss”. She could relax, and felt safe. After six weeks in hospital, Trisha was told that she wasn’t clinically depressed, so there was nothing to treat. Trisha felt dismissed. She had had a safe haven for a brief time, but that was all. She was discharged to a counsellor, but after several sessions Trisha felt that they were not achieving anything, so she stopped going.

Trisha became involved in prostitution which was initially a form of power-claiming; however after one and a half years Trisha realised she was still being used. At this point Trisha decided to get pregnant. She said she had “white-picket fence syndrome”. She had been with her boyfriend for several years and felt that a pregnancy would deepen his commitment and marriage and happiness would follow, but her boyfriend left her. Trisha was aged about 18.

Two or three years later Trisha went to counselling as she was exhausted by her son, who had been diagnosed with Attention-Deficit Disorder and was also sleep-disordered, waking every hour. Trisha had no support and no money, and consequently became very ill. Trisha received the maximum ACC payment for incest, and began counselling with Rape Crisis at around age 20. Trisha had counselling with Rape Crisis for two or three years, weekly or fortnightly at first, then in patches as needed over the next five years. During her 20s there were still many nights when Trisha wanted to commit suicide. “Even now that I’m 34 there are odd times, maybe once a year or so, when I need to cry and just tell someone what I live with in my past, as things still come up”.

Trisha also attended an incest survivors’ support group, and learnt she had every right to be “flakey”; feeling the way she did and to have made the choices she made. “I was validated and told clearly these were good choices, as they enabled me to survive”.

Wendy

Wendy was born in 1967; she is a Pakeha. Wendy was sexually abused from approximately age six by her older brother, and he also involved his friends in the abuse. The last incident was when Wendy was about 14 and her brother 20. She became very upset and thinks that her brother thought that she would disclose what had been going on. In addition, Wendy's father had a violent temper 'and some weird attitudes'. He was verbally abusive to her elder sister and Wendy once they reached puberty and Wendy said he made their teenage years a misery. He frequently accused Wendy and her sister of misbehaving and called them "sluts", without provocation.

For a long time Wendy refused to recognise the sexual abuse for what it was, preferring to minimise or block it out. However, in hindsight she said that although the sexual abuse itself was not particularly traumatic, the manipulations of her brother had a profound effect. The abuse was a major influence on how Wendy saw friendships. Wendy saw the abuse as normal playing for several years, and a few times tried to initiate it with other friends. She was rejected by these friends which left her feeling hurt and confused. Her brother took advantage of this, saying that no one liked her and she would never have any friends. This had the effect of making her very shy, and also reluctant to say no to 'playing' with him and his friends. Wendy still has some difficulty making friends; a sense of wariness and distrust remains. Wendy is sure her mother knew about the sexual abuse but chose to ignore it.

Although Wendy was very shy and lacking in social skills she did develop a few friendships. However, in her teens she became rebellious, in part because of her low self-esteem, and spent time with older people, "a bad crowd". She came to feel that if she was being treated by her father as if she was "doing all this bad stuff", she might as well do it. At this time her father was frequently telling her that she was worthless, and no decent man would ever want her. He also told her that she was not meant to have been born, she was an accident. Wendy was very hurt by these comments. She left home at 15 to live with her boyfriend. She was taking drugs during this time.

When she was 18 Wendy's father died. She found this difficult to cope with: she felt both numb and relieved, which left her feeling guilty. This led to depression. Her relationship had not been going well, and Wendy and her boyfriend split up shortly after her father's death. Wendy returned to her mother's home, feeling very depressed. "What my father had said was true – no one did want me, I was worthless and unlovable". Although Wendy's mother and sister must have realised she was severely depressed, nobody did anything to help her, and most of her friends lived in another city. After several months of being absolutely miserable, Wendy took an overdose. However, after she took it she became afraid of dying, and told her mother what she had done. Her mother took her to hospital. Wendy was given Ipecac to make her vomit, and she spent several days in hospital. She was also referred to a social worker. Things did not improve, and a month later Wendy took another overdose. Again, she became afraid of dying, and went to hospital. This time Wendy's stomach was pumped, which she describes as horrific. She was admitted for observation again, and referred to a mental hospital for assessment. This frightened Wendy, as she was afraid of going into a mental hospital. She also felt it "would be a bit pathetic to try a third time and not succeed, but I wasn't sure I wouldn't just chicken out again". She also did not want to risk having her stomach pumped again.

Wendy saw the hospital social worker several times, but found her to be no help whatsoever. Her family was also no help. Once she was released from hospital her suicide attempts were never spoken of again. Even when visiting her in hospital, her family did not speak about what was going on, except for her sister scolding Wendy for worrying their mother. Wendy was embarrassed by her suicide attempts and avoided talking about them with friends, except for the mother of a friend. This woman, Mary, had become a close friend, and Wendy found her to be a valuable source of support. Wendy continued to take drugs, and was referred to a drug abuse agency, which she said was some help. The doctor she saw there was understanding, and seemed to be interested in underlying problems, but Wendy never got close to telling him about what had happened. She says she would not have even admitted it to herself at that point. She did ask the doctor to admit her to a residential facility, but he said she did not seem to need it since she was making progress with reducing her drug use. Wendy said that at the time she wanted to be in a residential facility to

help her to cope with her depression, feelings of guilt and worthlessness, rather than the drugs, but she was not able to verbalise this.

Soon after this (about two months after the second suicide attempt) Wendy met a new man, and made some new friends through him, whom she moved in with. These new friends had gang connections. This gave her a real boost: although the relationship only lasted a few weeks, it helped get her past thinking that no one would ever like her, and although she remained somewhat on the periphery of the gang, she got a sense of belonging, and never felt judged. After a few months she began going out with another man who she met through the gang, and this developed into a long-term relationship. After two or three years they gradually withdrew from the gang, and Wendy felt much better, at least on the surface.

Although life had improved for Wendy, she still suffered from bouts of depression, shyness and lack of confidence socially, and verged on having an eating disorder. Eventually her marriage broke up. "There were many, nights when I went to bed praying I would not wake up in the morning, but I didn't do anything more active largely because I was afraid of failing and people finding out." Wendy was also too ashamed to admit the extent to which she was not coping. She saw a hypnotherapist, who she describes as a complete charlatan, and several other therapists. Shortly after this Wendy moved in with some other women, all of whom had had their own share of difficulties, and were extremely supportive. Wendy did not tell any-one the full story of her past, but she felt empowered by the strength and nurturing of her flatmates. She was able to deal with her past by herself sufficiently "so that I could function reasonably normally". After two years she had counselling with a clinical psychologist, which helped. Wendy has not felt suicidal for years now, and rarely gets depressed. She does still have some anger towards her brother and parents, but does not usually find it to be a problem. She has never fully revealed the extent of her abusive background to anyone, but said she now realises that none of it was her fault.

Yvonne

Yvonne was born in 1967. She was adopted as a baby, and is part-Asian. Her (adopted) father was an alcoholic, and frequently absent from the home, often for

weeks at a time. As Yvonne is from a large family, this meant that they experienced financial difficulties.

Yvonne also experienced difficulties in the first few years of school. She had poor eyesight but this was not discovered until her third year of school. Consequently she had fallen behind in her school-work and had low self-esteem. Her lack of confidence was exacerbated by the family's poverty. For example, usually her only pair of shoes were rubber sandals, and she would be teased about this during winter.

Yvonne described her childhood and teenage years as miserable, and she became a heavy drug user. She was raped when she was eight, and was sexually abused and raped by several other people during her teenage years. She also found her family difficult, as when her father was at home he was often violent. She was also expected to undertake care of her younger siblings.

Yvonne made her first suicide attempt when she was eight, by electrocution. She also took several deliberate drug overdoses as a teenager, and has self-mutilated (cutting).

She took one of her abusers to court, but he was not convicted. Yvonne knew of other women whom he had abused, but none of them wanted to go to court until after Yvonne's case, because they wanted to wait and see what would happen. As a result, none of the others proceeded. This lack of a conviction was a further blow for Yvonne.

Yvonne's final suicide attempt was at the age of 20. She jumped from the roof of a building. Yvonne was severely injured as a result, spending several months in hospital and more than a year in a wheel-chair. She said that the time in hospital gave her some respite, and she had several sessions with hospital social workers and counselling staff. This helped at the time, but once discharged from hospital she continued to find life difficult to cope with. In addition to her previous problems, she also had her lack of mobility to contend with.

Over the next three years Yvonne saw several counsellors, and engaged in group therapy, all of which was little help. During this period Yvonne self-mutilated, sometimes on a daily basis.

When aged 24, Yvonne became pregnant. This was a shock to her, as she had been told she would not be able to have children due to the injuries she had sustained. However, Yvonne described this as a turning point. She resolved to do all she could to overcome her depression and anxiety, in order to create a happy and stable environment for her child. Yvonne began doing re-birthing and counselling again, which she did find useful. She was able to talk to her adoptive parents about some issues and also contacted her birth mother. Although the development of a relationship with her birth mother has been stressful, it has allowed Yvonne to come to terms with her feelings of rejection.

While she still has bad days, Yvonne feels that she has recovered. She said there were a number of things that led to her recovery. While counselling did help, she often felt that counsellors did not really understand her. She recognises, though, that this was partly because she found it difficult to fully discuss her experiences, due to feelings of shame. Once she committed to therapy for the sake of her child, she pushed herself to be as open and honest as she could. She said this was very difficult, and it took some time to find a counsellor that she felt sufficiently comfortable with. She also noted a tendency on the part of counsellors and therapists to dwell on things. She said that she often felt pressured to continue to discuss and examine her experiences in more detail than she wished to; she could not see the point of going over every detail repeatedly. “I wanted to leave it behind me, but I felt like I was pushed to stay stuck in those dark times, going on and on about it.”

Table 7, below, tabulates the significant events prior to suicidal behaviour most commonly identified by participants. Chapter Six draws together the key themes from the participant interviews.

	Sexual abuse	Other abuse	Family suicide	Family death	Other suicide	Self- mutilation	Other self- harm
Anna							
Collette		Y	2 attempt				
Dana		Y	Attempt	parent			
Elaine			Attempt			Y	
Hayley	Y	Y				Y	Y
Heidi	Y					Y	Y
Jackie	Y	Y			Attempt	Y	
Jane		Y				Y	
Jen	Y		Comp	parents	Complete	Y	
Kate			2 comp.				
Lara	Y					Y	
Louise		Y			Attempt Complete	Y	
Lucy							
Maree	Y		Threat			Y	Y
Naomi	Y	Y				Y	Y
Patti	Y	Y	Attempt			Y	Y
Richelle	Y	Y	Attempt	? ²⁹		Y	Y
Rhonda	Y	Y				Y	Y
Robyn	? ³⁰	Y					
Sue	Y	Y				Y	
Tracey	Y						
Trisha	Y	Y	Complete Attempt	Murder		Y	
Wendy	Y	Y		parent	Attempt	Y	Y
Yvonne	Y	Y				Y	

Table 7: Most common self-identified significant events.

²⁹ Richelle is unsure of whether her step-sister was murdered or died of SIDS. See personal profiles.

³⁰ See Robyn's personal profile

CHAPTER SIX: COMPONENT TWO FINDINGS

This chapter deals with the results of the interviews from component two of the research, in which the participants who had formerly engaged in suicidal behaviour discussed their experiences. There were 24 participants in this component; Chapter Three provided details of the recruitment process and data collection methods and Chapter Five contains participants' case histories.

The findings are grouped into a number of sections, beginning with a brief presentation of quantitative material, such as the average number of suicide attempts made. This is followed by the presentation of qualitative material, which begins with an exploration of risk factors. This section includes other forms of self-harming behaviour that may accompany or be precursors to suicidal behaviour, such as self-mutilation. A matrix is provided at the end of this section, which outlines the more common risk factors and precursors that the participants experienced. A section on cessation follows which includes both therapeutic interventions and social support. As well as discussing support and treatments, this section also explores issues that participants felt had to be addressed in order for recovery to be possible. The final section explores prevention, with participants' advice for others.

Background and Initiating Factors

The following section presents the qualitative data gathered from participant interviews. It begins with individual, personal topics such as biological factors and moves through to social factors. This is followed by an exploration of non-suicidal self-harming behaviours that the participants considered relevant. Some of the most salient experiences are presented in a matrix at the end of the section.

In the majority of cases participants were simply asked 'What do you think led to you becoming suicidal?' Although some started by saying something along the lines of 'It's hard to pinpoint exactly why', most immediately began talking about specific events in their early years or their family background without further prompting. A few began with the circumstances surrounding their first suicide attempt, for example Maree:

“At 16 – I’m not even sure. I was just really unhappy. At 23, it was breaking up with my husband, being on my own, going on the DPB, not liking myself, thinking I was unlovable, trying to get it together and not being able to”

and then moved immediately to earlier events:

“My Mum had been suicidal as I was growing up and had attempted suicide at least once that I know of. Her and Dad were unhappy. My older brother sexually abused me when I was ten. We were also very religious ... I always felt different and like I didn’t know how to belong especially when I left the church at 16.”

Biological/Pathological Factors

For almost all the participants there was a combination of factors that led to their suicidal behaviour; all spoke of family-related issues, usually going back some years, as well as more immediate issues. However two women felt that the major problem was biological:

Kate: “I now see depression as the same as diabetes or a cholesterol problem. Mental illness should be accepted in that light. It is genetic in my family and it pisses me off that people don’t understand.”

Lucy considered her suicidal period as being completely attributable to going on the contraceptive pill. While Lucy acknowledged that stressful events occurred at the time, she has never felt that level of depression before or since, and she had just started on the pill. Within two weeks of stopping the pill she “was back to normal. Thank God I didn’t die!” Her doctor also attributed her suicidal behaviour to the pill; indeed, it was her doctor who made the connection.

Biological factors also seem important in Dana and Lara’s cases. Although Dana had experienced some depression previously, particularly around the death of her father when she was 13, it was after the birth of her child when she was 18 that she became suicidal. Her mother also suffered from post-natal depression, but Dana continues to struggle with depression nine years after the birth of her child. Lara has a medical condition that is associated with depression. However, she also identified a number of stressful life events as contributing to her suicidal behaviour, including sexual

abuse and the eventual death of her brother after a long illness. Clearly, although biological factors have been implicated in some cases, social factors also play a role.

All other participants had identified a combination of life events as being the key factors in their suicidal behaviour, but several participants appear to have a family history of alcoholism, depression and suicidal behaviour (discussed below). It is unclear how much of this is genetic and how much has resulted from learned behaviour (or normalisation of suicidal behaviour) among the participants. It seems that many participants would have fitted the clinical criteria for depression at the time of their suicidal behaviour, although few were diagnosed. In addition, three participants were diagnosed with Borderline Personality Disorder, two with Post-Traumatic Stress Disorder and one with Dissociative Identity Disorder/Multiple Personality Disorder.

Abuse

With the exception of Lucy and Kate, all the participants had experienced some form of abuse or neglect.

Sexual abuse. Fifteen of the twenty-four participants had been sexually abused; it is also possible that not all participants disclosed abuse in the course of the research; indeed, one woman did not disclose during the interview, but contacted me afterwards to discuss this. In addition, two of the remaining participants identified the loss of their virginity as being a key precipitator to a suicide attempt. In both these cases, the young women had religious backgrounds, and alcohol had been consumed. Although neither considered that rape had occurred, it seems that a degree of coercion was involved.

Louise: "I lost my virginity during the fourth-fifth form summer break. I didn't want to, but I was drunk."

In another case the first consensual sexual intercourse precipitated a suicide attempt. Heidi had been sexually abused over several years from a young age, and although she decided to have sex with her boyfriend, she "freaked out".

Of the fifteen who had been sexually abused, in most cases a family member was a perpetrator (in two cases there was more than one abuser). In three cases the

perpetrator was their father or step-father, in three cases it was a brother, in two cases it was their maternal grandfather and three women chose not to specify the exact nature of the family relationship.

Of the five cases in which the abuser, or one of the abusers, was not a family member, in three cases there were still links with the family: in one case the participant's brother's friends were abusers, and in two cases the mother's boyfriend was the perpetrator. Three participants did not specify their relationship to the abuser.

All these women identified sexual abuse was a significant factor in becoming suicidal:

Lara: "I had a total lack of self-worth"

Wendy:

The abuse [by Wendy's older brother] had a big effect on how I saw friendships, and this was made worse because my brother involved his friends and another girl I went to school with. I saw the abuse as normal playing for several years, and a few times I tried to initiate it with other friends, when I was about seven. I was rejected by these friends ... I felt hurt and confused. My brother took advantage of that, saying that no one liked me and I'd never have any friends. So I became very shy, and also reluctant to say no to 'playing' with him and his friends.

Heidi:

I hated men, I had violent fantasies and was uncomfortable with being touched. The abuse made me feel bad and evil, so I gravitated towards doing things or being with bad, evil people... My Christian upbringing taught me that character was linked to chastity, and I had lost my chastity.

Jackie continues to have great difficulty talking about the sexual abuse she suffered. She was only able to refer to the topic by saying:

Stuff happened that I can't really talk about... I always tried not to think about it, so when I started cutting and attempting suicide I didn't think about it being because of 'it'... I just blocked 'it' out... It's not like I forgot about it though. Looking back it was a big part of why. I hated myself, but I didn't make a conscious connection.

Jackie was able to indicate that 'it' was sexual abuse, but did not discuss details of the abuse.

For several participants the impact of sexual abuse was exacerbated by issues around receiving help or disclosure.

Wendy:

I'm sure my mother knew or at least suspected – she did make some efforts to prevent my brother and me being alone – but she didn't do anything that actually stopped the abuse. She didn't tell Dad, she didn't try to get any outside help, she didn't even talk to me about it. I know she probably didn't have the resources to deal with it. She probably was trying to pretend it wasn't happening, but at the end of the day I was helpless. She knew and she didn't help me. It went on for years, and I'll never forgive her.

Some of the women did not disclose the abuse for some years, and one never had disclosed it prior to taking part in the research. For some, simply having no one to confide in was a source of distress. Of those that did disclose, three were not believed.

Naomi:

I told my mother about the abuse but she didn't believe me. This led to my step-father taking a dislike to me. I was also physically abused by my step-father, and Mum always took his side. It was a mutual

decision for me to go to boarding school then,
although it felt like I had no choice.

Some years later Naomi's mother told her that she did believe her, but when Naomi told her more of the details her mother told other family members that Naomi was making up stories.

After her mother killed herself and Trisha's sister, Trisha's father had begun sexually abusing her. Trisha:

What had happened was too terrible for me to put
into words [while it was happening]... [Eventually] I
saw the family doctor, but he questioned the accuracy
of what I was saying, which was devastating. It took
my last drop of courage to tell him, and then I wasn't
believed.

Jen:

During the school holidays I went to stay with my
older sister, who was married by this time. I was
molested by my sister's father-in-law during [these]
holidays. When I told my sister she didn't believe me,
so I still had to go back every holidays.

Both Jen's parents were dead and she was living in a boarding school.

Three participants no longer have a relationship with their mother because they were not believed when they disclosed abuse by their step-father or mother's boyfriend. Two participants, Jackie and Lara, spoke about disclosing abuse to mental health workers and being told that the abuse "didn't count", or that it was "just kids playing". In Jackie's case, this was the first time she had disclosed the abuse. Both found having their experiences minimised in this way to be disempowering: "It counted to me, it had been one of the main causes of me feeling like I did and hating myself." Jackie has not been able to talk about the abuse since, although she feels pressured to do so by her current therapist.

In the two cases that involved the maternal grandfather, the participants' mother had also been abused by the same man, but had not previously disclosed it. In these two

cases the abuse of mother and daughter, when disclosed, led to additional disruption through feelings of guilt, anger and shame on the part of the participant's mother. Heidi: "My mother had a breakdown as a result – she had blocked out her own experience of abuse." Heidi's mother was admitted to hospital briefly.

After she came out of hospital I more or less began parenting my mother. Mum felt she had to stop seeing her family, who had been a huge source of support for us. We were virtually disowned, although I'd been my grandparents' 'princess'. My grandfather refused to get help.

Heidi and her mother sought help from their church and were told to "forgive and forget". They did not find this approach helpful.

Of the fifteen who had been sexually abused, four took court proceedings. Of these, only one can really be described as having a positive outcome:

Sue: "I got a sense of control when I went to court. He had taken my power away, but now he's in jail and I've got some power back."

Of the other three, one found the process devastating, and it led directly to suicidal behaviour:

Heidi: "The decision to take him to court was a disaster. I had to give an evidential interview and that was the end really. I hated myself, I wanted to die, I was so depressed. The interview was fucking horrible...Character and chastity are tied together in my family and I felt evil".

Yvonne took one of her abusers to court but he was not convicted. Yvonne knew of other women who had been abused by him, but none of them wanted to report it until after Yvonne's case, because they wanted to see what would happen. As a result, none of the others proceeded. This was a 'slap in the face' for Yvonne, as she felt her experience was invalidated.

Although Richelle's father was found guilty of rape and is serving a prison sentence, he remains adamant that he is innocent, which, for Richelle, to some degree negates the effect of his being convicted.

In addition, after being sexually abused, three participants were raped by someone outside the family, in unrelated incidents.

Physical Abuse. Nine participants talked about physical abuse (other than sexual abuse) as a factor in becoming suicidal. Usually this was inflicted by a parent or step-parent, although Patti said:

The trauma I suffered was from being tortured by a neighbour who was mentally unstable – this was a one-off thing – I was about seven and only have fragmented memories of it. I was also sexually abused.

Several participants also witnessed violence directed at their mother by their father or step-father and discussed the distress this caused them.

Emotional Abuse. Almost all of those who were sexually abused within the family also talked about emotional abuse.

Wendy:

At this time my father was frequently telling me that I was worthless, and no decent man would ever want me. He also told me that I wasn't meant to have been born, I was an accident. I took [these comments] to heart.

Wendy also discussed her brother using her shyness and lack of confidence to facilitate his continuing to sexually abuse her.

Richelle: "My mother was very controlling. My life was completely punctuated by conflict."

Jackie:

When I was about 10, I realised that my family was screwed up and not like other people's families. My father is an alcoholic. Although he wasn't directly abusive, he could be scary, cruel and unpredictable... when my little brother was learning to walk, my father would trip him up, and hold him down when he was

trying to get up... Mum was apathetic, and they would complain about each other to me, using me as a pawn. Like they would talk about getting divorced and try to make me pick who I was going to live with.

Jane: "Words don't leave you, they define you."

Many of these participants spoke passionately of the distress this abuse caused them. In addition to being a source of depression and/or anxiety, the emotional abuse contributed to poor self-esteem and feelings of powerlessness and hopelessness.

Neglect

In addition to abuse, five participants talked about feeling ignored by their family.

Anna:

My father was a sales rep and therefore seldom home. There is no question of abuse, but there was a lack of care. My parents' preferred my sister.

Wendy:

I remember one time when I went away on a primary school camp. When I got home I was quite excited, and started telling Dad where we'd been, what we'd done. He just looked at me and said 'Have you been away?'.

For these women, the result of this neglect was a feeling of being unloved. This seems to have translated into feeling unworthy of love, in turn impacting self-confidence.

Other Family Factors

All participants except Kate identified some family conflict or dysfunction as contributing to their suicidal behaviour. Many participants identified conflict between their parents. Deaths in the family also seem unusually common,

considering the age group. Table 8, below, gave a breakdown of the various stressors encountered.

Stressor experienced	Participants
Parental divorce/separation	Tracey, Sue, Robyn, Richelle, Naomi, Maree, Heidi, Collette
Parental conflict, but not separation	Patti, Louise, Jackie, Evelyn, Anna
Parental substance abuse (most commonly alcohol)	Yvonne, Patti, Jackie, Dana
Financial difficulties	Yvonne, Jane, Evelyn
Parental Schizophrenia	Collette
Religious beliefs	Jane, Heidi, Maree, Patti
Family suicidal history (threat, attempt, or complete)	Collette, Dana, Evelyn, Jen, Kate, Maree, Patti, Richelle, Trisha
Parental death	Dana, Jen (both parents), Trisha, Wendy. (including two suicides)
Other death in family	Richelle (possible murder of half-sister), Trisha (murder of sister)
Other dysfunction, e.g. violence from father directed at mother	Louise, Patti

Table 8: Sources of stress occurring within the participants’ families.

Of those with a family history of suicidal behaviour, one involved the mother threatening suicide, five involved either the mother or brother making an attempt, and four involved a completed suicide: in two cases, the mother and in one case, both grandmothers. In addition, several women also suspect (with hindsight) that their mothers suffered severe depression although they do not appear to have been suicidal.

Four participants spoke about their family’s religious beliefs being a source of stress. In some cases this was due to the religion requiring a degree of social isolation. In others it was due to the participants’ beliefs diverging from their parents as they grew

up, resulting in conflict. In one case the church's handling of the abuse perpetrated by one of its members on the participant further exacerbated the situation.

Social Isolation

Social isolation was implicit in most participants' stories. In most cases this was due to shyness and a lack of confidence, although in one case it was deliberate on the part of her parents:

Richelle: "We were home-schooled and kept isolated. When I was about 14 I was allowed ballet and piano lessons, but before that we had no social contact with anyone whatsoever. Even at lessons, mum was always there, and I was not allowed to talk more than was necessary, on the threat of the lessons being cancelled". When Richelle was older and had left home she continued to find it very hard to interact with other people.

Many participants spoke more generally about being shy or feeling like a 'nerd' or a 'geek' or generally not fitting in and having few friends. For others social isolation came about once they became depressed:

Evelyn: "I felt like no-one understood, I didn't enjoy anything and started spending lots of time on my own"

Collette: "I felt like I was in a bubble and couldn't connect with anyone."

As mentioned elsewhere, religious beliefs had an ostracising effect for some, such as Maree and Jane. In three cases a participant's boyfriend isolated her from her friends, with the result that she was left alone when the relationship ended.

Tracey: "When we split up I was left with hardly any friends because most of them believed him when he denied that he'd beat me up"

Robyn: "Once we shifted...I had no friends of my own, only my boyfriend's friends, and they sided with him. He'd go off with them leaving me alone."

Jen was sent to boarding school in a city where she knew no-one, shortly after her parents' deaths.

Wendy's brother encouraged her feelings of social inadequacy and resulting isolation in order to facilitate continued abuse, as discussed above.

Relationship Problems

For young women who already have self-esteem issues, breaking up with a boyfriend or partner can be devastating:

Maree:

At 23, it [the cause of the suicide attempt] was breaking up with my husband, going on the DPB, not liking myself, thinking I was unlovable, trying to get it together and not being able to get control – hating myself for my behaviour and not being able to get over it.

Heidi: “I broke up with my boyfriend and that was disastrous, partly because we had a sexual relationship, and that was special for me”

Five others talked about relationships that were unhealthy, but that they had persevered with because their boyfriend made them feel loved, despite the problems. For example:

Tracey: “Although he was violent, he could also be affectionate, and I thought he loved me. The end of the relationship marked the beginning of a downward spiral.”

Collette:

I had a boyfriend... a ‘hard man’, a rugby nut, he was very controlling of my behaviour, what I wore... I did have some misgivings about the relationship, but I wanted love. He was offered the opportunity to play rugby in England, so we broke the relationship off, which was the lowest point for me. I was feeling rejected, mostly by my birth father, but by others too. Although there had been some problems in my relationship with my boyfriend, I was able to talk to him and he understood how I felt, and made me feel loved and cared for, although some of his actions

were not loving. I was quite shy and had few friends
– I felt like a loner without my boyfriend.

Sexual Orientation

When discussions relating to the question “What lead to you becoming suicidal” appeared to be coming to an end, I asked participants “Is there anything else that you think is important, such as relationships with family or whanau; relationships with peers; love relationships; school or work or unemployment; or sexual identity?”

Three of the participants mentioned that they are lesbians. For Lara and Hayley, their sexuality added to feelings of inadequacy.

Lara: “When I realised I was a lesbian at 13 I experienced a lot of depression. I already felt shy and inferior and lacking. There’s a really narrow band of what’s acceptable, and I wasn’t in it.”

Hayley: “When I came out as a lesbian I got a really hard time, particularly from my brother.”

However, both women stress that their sexuality was only a part of the problem.

Rhonda said, “I came out as gay but I’m okay with it and it was never a real issue for me”.

Although more than half the participants had been sexually abused, only one explicitly mentioned her (hetero) sexuality as a problem for her; Heidi talked about how special her first consensual sexual relationship was and how upset she was when it ended. Nobody else talked about sexual abuse resulting in concerns about sexual relationships, although two participants became sex workers. One of these, Heidi, suggested that there is a belief that girls who’ve been sexually abused go on to become sex workers: “It’s important to know that your life is not necessarily wrecked [as a result of sexual abuse]. Not everyone becomes a sex worker, not everyone wants to kill themselves. It isn’t inevitable. It took me a while to figure that out.”

Loss

Four participants mention the death of a parent as being devastating. In Jen's case, her father died, and a month later her mother committed suicide. Trisha's mother killed herself and Trisha's little sister.

For Evelyn the loss was of her sport. She was a New Zealand champion for several years and competed internationally. She had put all her time and energy into it, letting schoolwork and friendships come second.

I was badly injured when I was 17. I felt that sport was my life, everything revolved around it, and I didn't know who I was without it. I was given very little support around the injury by my coach and manager; they implied it wasn't as serious as I was making out. My friends and family encouraged me to continue as well, despite the pain I was in. There was just so much pressure.

Heidi used sport as a way of channelling and dealing with negative emotions largely centred on sexual abuse. However, she also developed an injury and had to discontinue her sport. Although the loss of her sport was not a primary cause of suicidal behaviour, once this coping mechanism was removed she struggled to deal constructively with her emotions. Anna also discussed the loss of sport as contributing to her suicidality. Being 'sporty' was an important source of self-esteem for Anna.

Control/Power

Issues of power and control seem to be implicit in most, if not every, participant's story.

Participants spoke of not being in control of a variety of aspects of their lives including:

- Relationships, with
 - Abuser
 - Parent(s)
 - Partner
 - Counsellor
- Emotions

- School results

This resulted in feelings of hopelessness, helplessness, fear of the future, fear of escalating emotions, worthlessness, and fear of further abuse.

Participants attempted to regain a sense of control via:

- Risk-taking
- Under or over-eating
- Substance abuse
- Self-mutilating
- Suicidal behaviour
- Pretending to be unaffected, 'cool', blasé
- Getting a conviction against an abuser
- Creating a state of un/semi consciousness

Participants spoke of these behaviours as reclaiming their body, their life/death, delineating a boundary, and creating a sense of ownership.

Richelle: "I knew I didn't have enough pills to kill myself, but life was so unbearable and out of control that the promise of being unconscious for a couple of hours or days was enough."

Rhonda: "The damage continued in my adult life until I disentangled myself from my parents and their control of me."

Taking control or responsibility, while empowering, could also be a source of stress:

Richelle: "My new shrink wouldn't commit me against my will so although in a way that's what I wanted it also increased my tension and stress in terms of should I kill myself or not. No one else was going to rescue me and that was very scary."

Jen:

I felt I had absolutely no control – I was suddenly among 150 girls I didn't know [in boarding school] and had no control over the most basic functions...I had to go to my sister's for holidays, despite being molested there...the psychologist badgered me for details of my sex

life and I knew that approach was completely wrong but I felt like I had to go. I felt absolutely powerless, I *was* absolutely powerless. My depression took a turn I couldn't control, and I was over the edge.... I felt that nothing was in my control except my life itself.

Four participants talked about concerns around their weight, and focusing on getting control of this, in some cases resulting in anorexia or bulimia.

The issue of control also seems pertinent to counselling/therapy. This will be discussed in the cessation section.

Self-esteem

Self-esteem is another issue that is inherent in all the participants' narratives, and many spoke explicitly about their lack of confidence.

Rhonda: "The abuse contributed to my self-hatred and self-loathing and I never felt good enough."

Wendy speaks about the deliberate manipulations of her sexually-abusive brother to lower her self-esteem and socially isolate her. In addition:

My father had some really weird attitudes. Up until the age of 12 I was his little angel, then as soon as I hit puberty he became really verbally abusive towards, calling me a slut ... I didn't even know what the words meant, I was totally confused. He was the same with my sister. He used to say I was worthless, that no decent man would ever want me, that I wasn't meant to have been born, I was an accident. Of course, I believed him.

For Anna, being taunted and bullied contributed to a feeling of failing academically and personally which, she said, ultimately resulted in her suicide attempt. This occurred against a background of family difficulties, loss of self-identity due to a sporting accident, combined with the stress of starting university in a new city. She had been depressed for some time, and the feeling of failure was "the final blow".

Many participants spoke of the impact their family had on their self-esteem, particularly their fathers.

Collette speaks of the rejection of being adopted, growing up in a dysfunctional family with a schizophrenic step-father, and shyness leading to loneliness. She was socially isolated and said she felt like “a loner and a loser”.

Hayley said she had always had low self-esteem although she was unsure why; she suggested that it may have resulted from an overly authoritarian family. She had begun to self-mutilate and restricted her eating in order to punish herself, and to distract herself from her unhappiness. When she developed an eating disorder her father denied that there was a problem, telling her to “pull her socks up”. She said

It's hard to work on your problems when your
parents deny they exist. I felt like a fraud, and
sometimes I wondered if I was just attention-seeking.
This made me feel worse about myself, and I felt like
I was wasting people's time. I didn't feel worthy of
people's time and attention.

As a result Hayley had difficulty in asking for help. When her eating disorder and self-mutilation failed to serve their purposes she attempted suicide.

Yvonne: “My father gave me a hard time about being big, called me a fat cow and told me I would do better in my sport if I wasn't so big”. Yvonne was a New Zealand representative in her sport.

Louise's father made similar criticisms: “My dad used to call me fat, and one time I tried really hard to lose weight, dieted and exercised really hard, and no-one noticed, even when I asked them. I was really pissed off.”

Both women spoke of feeling depressed and inadequate as a result of these comments.

School

Schooling difficulties appeared to be a problem only for those participants who had excelled academically then had a failure, or as a site of social problems such as loneliness due to social isolation. An example of the latter is Yvonne, who had had difficulties in her early education due to unrecognised eyesight problems. She said that even after she got glasses she felt “dumb” and little effort was made to help her

catch up to her peer group. Instead, she was put in classes with younger students, where she felt lonely and out of place.

Louise:

Because I was in a top-stream class I had to take science-based subjects, which I didn't enjoy or understand. I failed them which was really hard because I was used to succeeding at school, so I lost my motivation...I only went to school to meet with my friends...we egged each other on when it came to missing school, getting stoned before exams...I'd always been a nerd at school and now nothing seemed to be going right, I felt like I had nothing to look forward to and I didn't like myself.

Wendy:

I'd always done very well at school – it always came easily for me, I never had to study, and I'd been in special advanced classes for some subjects. Then when I was in the fourth form I started wagging school, was always late. I wasn't often really naughty though, but I was really unhappy because of the other stuff that was going on at home. I ran away at the end of fourth form and missed the last few weeks, so at the start of fifth form they took me out of the top-stream class and put me in the bottom stream. Nobody ever thought to question why things had suddenly changed – I had been a star pupil for years, and suddenly I was losing it. I can only think that they did it as a sort of punishment – my marks were still ok, they had dropped, but I was still getting some As and Bs. So that was the end really. I'd already done all the stuff they were teaching, there was no point, so I just stopped going.

Anna and Evelyn were the only participants who spoke of ongoing pressure to perform at school as a key issue in their suicidal behaviour.

Anna: "My childhood depression was as a result of pressure to succeed, both in terms of school work, but also in life generally...my sister was a 'golden child' and I felt pressured to live up to the standards she had set." Anna also speaks of her

struggle with some papers while at university as contributing to an overall sense of failure.

In addition to schoolwork and social isolation, a number of participants discussed other issues associated with school:

Hayley: “If school hadn’t also been so focused on weight charts it might not have seemed like an issue”. Hayley became anorexic when told that she would have to lose weight if she was to be a bridesmaid at a family wedding.

Naomi had a similar experience at drama school, when the director of a production told her she had to lose weight. Naomi already had a background of sexual abuse and estrangement from her mother, so this was ‘the final straw’ that led to her becoming anorexic, then self-mutilating.

Heidi also mentions a “crappy, humiliating teacher’ who had a severe impact on her self-esteem, despite her having been doing well academically, and Wendy’s experiences were similar.

After the death of Jen’s parents the Public Trust took over the family’s affairs. Jen was asked if she wanted to go to boarding school:

To which I replied with a vehement ‘no!’ but I was sent anyway. I’d never been to the city where the school was and I knew no-one.

Before I arrived the headmistress explained to the other girls that my parents had recently died, so everyone treated me differently. I found suddenly being with 150 girls very hard, and I felt completely powerless.

Of the 23 participants, only three directly attribute lack of academic performance as contributing to their suicidal behaviour, and it is clear that this is only one of several factors; they already had self-esteem issues which academic problems exacerbated. Given the emphasis placed on schooling difficulties in the literature this was a surprise. While a closer examination of the literature is warranted – I may have assumed too narrow a definition of ‘educational difficulties’ – perhaps there are other explanations. Apart from sample size, perhaps gender is an issue here. Maybe

academic failure is, or has been, more of an issue for young men, and this has influenced the literature. Some the literature that lists educational difficulties as an important risk factor is based on research conducted on the families of young men who have completed suicide and refer to a failed examination (or similar) shortly before the suicide. In addition, much of this research has been conducted in the United States of America; perhaps academic success is valued less in New Zealand.

Behaviour Change

Although not risk factors in themselves, participants identified a number of indicators of distress. Some of these warning signs seemed easy to miss, particularly those around internalising behaviour, such as social withdrawal. As Kate noted: “My school reported remarked on how very quiet I was. This was taken to mean that I was very good, but it was because I was so terribly shy and lacking in confidence, socially withdrawn.”

Jane’s social withdrawal was of a more dramatic and obvious nature, but still did not result in effective steps being taken by care-givers to attend to her distress:

I decided to become mute when I was 17. This lasted about 9 months... Within my family this mute period is referred to as ‘when Jane was sick’. I decided to stop making any noise as a containment mechanism – I was afraid of breaking. It helped me to feel in control.

A wide range of common externalising behaviours were discussed by many participants. These include ‘wagging’ school, mixing with ‘undesirable’ friends and boyfriends, ‘hanging out on the streets’ and disruptive behaviour at school. In addition the more serious behaviours of drug-taking, self-mutilating and the like were explored and are discussed in more depth below. Although sometimes discussed as risk factors for suicidal behaviour, particularly when labelled as a conduct disorder, personality disorder or substance abuse, the participants in this study spoke of them in a way that suggested they were coping mechanisms.

Trisha spoke about a variety of risk-taking behaviours, including:

Taking drugs, hanging out with a bad crowd, walking down the road in the middle of the night, sleeping with anyone I thought wouldn't harm me in exchange for food and a bed, so that I didn't have to go home.

Self-harming Behaviour in Social Networks

Support groups for self-harmers. Several participants mentioned joining support groups to deal with various forms of self-harming behaviour. While Sue suggested that having a support group for people who cut or have made suicide attempts would be a source of non-judgemental support, Richelle pointed out that:

I didn't begin cutting myself until I met a cutter in hospital [after being hospitalised for a suicide attempt] and I didn't actually need stitches until I joined a support group and met some more cutters. It was physically difficult to cut deep at first – I had to learn how to do it...we were both good and bad for each other. If one of us cut we all would, but there was lots of support for each other when things were going well.

Jackie reported similar experiences. She had been cutting herself superficially for some time before meeting a cutter at a support group for students suffering from depression:

Linda was exactly like me, another cutter, attending [the same treatment facility], and feeling suicidal. There was an instant affinity and understanding... A couple of weeks after we met we got really drunk and cut together. This was the first time I cut really deeply. Linda had been cutting more deeply than me and she gave me a sharper knife and sort of encouraged me.... Then I moved in with Linda, about a month after meeting her. My psychologist said it wasn't ethical for her to continue seeing me, as I didn't seem to be interested in helping myself. The psychologist said I had to make a choice between Linda and her [the psychologist]. I chose Linda... At that time I thought taking an overdose was an ok thing to do – it was a way of trying to get some-one to do something. Linda had never OD'd, so she took an overdose with me there to call the CAT team. I took her

to hospital, stopping to buy alcohol on the way, so it would be worse. The next day we both OD'd on 121 pills. This was a real attempt to die. That was when I really grasped the idea that I could die, after being admitted to HDU, then ICU then the psyc ward.”

Naomi made similar comments, pointing out that:

Support groups can be helpful, but also dangerous. I learnt new ways of losing weight from other anorexics, and I think the same thing could happen with other self-harm support groups.

Suicidal behaviour in friends and family. Nine of the 24 participants mentioned suicidal behaviour of some type on the part of a family member and another three mention completed suicides in their social circle; although none discussed it at any length, several mention that others' suicidal behaviour raised suicide as an option. Jen mentions the suicide of a neighbour:

He killed himself about a year before my parents died. He had terminal cancer. I was hugely affected by it. I thought about it a lot, what he'd been feeling and thinking. I was really moody and introspective at the time.

Jen was about 13 at that time. Her mother died a month after her father; Jen was told, “She died of a broken heart, but I'm sure that was a euphemism covering up that she'd killed herself”. She now wonders whether a different handling of the death of the neighbour would have changed her attitude to suicide and possibly also her mother's.

A friend of Louise's also committed suicide:

It was an important influence. After it happened Mum talked to me about it, and I said I wouldn't do it, but I was thinking ‘why not?’. My friend seemed normal, so suicide wouldn't be a big deal. The school also took some steps to deal with the aftermath, but it made no difference to how I was feeling.

Patti:

[When growing up] I knew older people who had committed suicide and thought they were nuts! Now I have a greater empathy and understanding towards it. I have four friends who have successfully killed themselves and I've seen the effects it has had on family and friends.

Yet Patti made several suicide attempts while in her early 20s.

Collette's step-mother had tried to commit suicide in front of Collette before Collette became suicidal, which clearly did not prevent Collette's suicidal behaviour.

However, when another relative completed suicide while Collette was in the midst of her own suicidal phase, it made Collette re-evaluate her life and the consequences of suicide for her family.

Financial Stress. Three participants mentioned a lack of money or resources as a source of stress within the family. However, this appeared to be considered relatively minor; we can only speculate on how much financial pressure contributed to stress and dysfunction within the family, and lack of access to resources that may have proved beneficial or preventative of suicidal behaviour. Participants were from a range of backgrounds, describing theirs as a 'normal working family' through to 'privileged in terms of resources'

Summary of risk factors

While there is an overlap, risk factors can be divided into distal (background factors) and proximal (immediate) factors, or triggers. It should be noted, though, that this distinction is not always easily made. Some participants began thinking about or attempting suicide at an early age, while what are background factors for the majority were actually taking place. For example, of those that were sexually abused, only one, Yvonne, made a suicide attempt at the time; the others did not engage in suicidal behaviour until some years later, although they all considered the abuse to be the major factor underlying their suicidal behaviour. For Yvonne, sexual abuse was both a proximal factor and a distal factor as she continued to engage in suicidal behaviour for some years after the abuse ceased, while for the others it was a distal factor.

Distal Factors

With the exclusion of the two women who consider that their suicidal behaviour was primarily due to biological causes (Kate and Lucy), *all* the participants spoke of issues within their family being key contributors. While the divorce of parents does not seem particularly common (seven out of 24 participants) most of the others spoke of a large amount of parental conflict that did not result in divorce. Additionally there were five parental deaths, two of which were suicides, and a number of other issues as discussed above.

Sexual abuse was more commonly reported than would be expected from statistics which suggested prevalence rates of between 17 and 38%; 15³¹ of 24 participants reported sexual abuse, usually perpetrated by a family member.

Almost all participants spoke of some level of physical or emotional abuse within the family that was sufficiently severe to be considered a cause of their suicidal behaviour.

Shyness and lack of confidence or low self-esteem resulting in social isolation was considered a contributing factor by approximately half the participants. This was often attributed to the effects of abuse, and in some cases to 'feeling different' because of religious beliefs. In one case social isolation appears to have been deliberate on the part of the parents.

Many participants spoke explicitly of feeling powerless or out of control of some aspect of their lives, often as a direct result of abuse. This loss of control was usually sited by participants either in the body (abuse) or emotions (feeling that depression was out of control, for example). In some cases it was of a more practical nature; Jen speaks of her boarding school experiences, Maree of being on the Domestic Purposes Benefit.

³¹ Sixteen, if we include Robyn, who suspects, but does not remember sexual abuse.

Proximal Factors

A range of more immediate factors compounded the background issues and were the triggers for suicide attempts.

Loss of self-identity was mentioned by a number of participants, in several cases because of issues at school (see Wendy and Louise for example), but three participants spoke of a sporting injury being the cause; being a successful sportswoman was important to their self-concept, and when injury meant they had to give up their sport they felt, as Evelyn puts it, “like I didn’t know who I was anymore.”

Relationship break-up was mentioned by a number of participants as a trigger.

Other factors discussed, but which appear to concern relatively few participants are sexuality, academic failure per se, and the influence of friends.

The overall impression is that without the distal factors the suicide attempt would not have occurred; the proximal factors were not sufficient cause in themselves. This appears somewhat at odds with the results of stage one; although background factors were acknowledged by all key informants, some appeared to place the emphasis (in treatment/recovery at least) on dealing with the immediate ‘triggers’.

Non-suicidal Self-harming Behaviour

In addition to behaviour of suicidal intent, many participants engaged in self-harming behaviour for which the goal was not suicidal. As discussed near the beginning of this chapter, many participants engaged in self-mutilation; several participants also engaged in substance abuse or had eating disorders. The following section presents the participants views of these behaviours and disorders.

Substance abuse

Eleven of the 23 participants discussed substance abuse. For one participant, this was confined to frequent excessive drinking, two included marijuana use, and the remaining eight abused a variety of drugs, in some cases prescribed anti-depressants, tranquillisers or sleeping pills as well as illegal substances. For the most part this

appears to have been ‘self-medicating’ – a way of escape. Most spoke about their drug use in a way that suggested it was the norm in their social circle at the time, although Louise commented that her drinking and drug-taking was initially in conflict with her Christian beliefs. Louise said:

I was finding it increasingly difficult to fit Christianity with my weekend behaviour, especially as the YFC leader knew about my weekends, so I gave up Christianity in the fifth form. I never really liked myself during this time. I was concerned about my weight - my dad used to call me fat - and I didn’t like hearing about my weekend behaviour at school on Monday, but if I didn’t go out drinking I felt like I was missing out. During fifth form I went from being religious to being a drunken slut.

As with eating disorders, it appears that in most cases substance abuse began some time before the first suicide attempt – in some cases several years – and continued after the last suicide attempt. Nine of the participants that abused substances started doing so before their first suicide attempt. One of the two that did not, Yvonne, made her first suicide attempt at the age of eight and began her drug use in her early teens; the other, Anna, made her only suicide attempt at age 18, around the time she began drinking. Her alcohol use increased after the suicide attempt, and she began using other drugs.

One participant, Wendy, mentioned receiving treatment for substance abuse. She thinks this was largely because

I was referred to a mental hospital after my second suicide attempt and I was scared of being admitted, so I pretended that it was accidental, that I just wanted to get stoned. Better to be [labelled] a druggie than a suicide attempter!

Eating Disorders

Six participants spoke of having an eating disorder, and one other spoke of “being on the verge”. This is somewhat fewer than possibly expected, given that presumably eating disorders are more common than suicidal behaviour, as discussed in Chapter

Two, and both behaviours are signs of emotional distress. For all of these woman the eating disorder developed prior to self-mutilation or suicide attempt, and in all cases except one continued beyond their last suicide attempt. These six participants spoke of excessive control of their eating as being a way of dealing with emotional distress. However, at some point, it no longer performed this role effectively.

Only two participants mentioned receiving treatment for an eating disorder.

Self-mutilation

Seventeen of the 24 participants discussed engaging in self-mutilation, such as cutting or burning oneself. Cutting was the most popular, with 14 engaging in this activity. Four participants burnt themselves, one caused friction burns through excessive scratching and two bruised themselves through hitting or kicking objects. Several participants engaged in more than one variety of self-mutilation.

All participants stated that this self-mutilation is different from a suicide attempt.

Richelle:

Cutting is playing with dying – it is not consciously wanting to die... It's a means of self-expression, stress and tension-relief. It made me sane when I was going crazy. It is not really any different from smoking or drinking except that it is not socially acceptable.

Evelyn, Louise, Wendy and Sue describe cutting as an expression of anger, while Hayley began to burn herself as a punishment for eating when she was anorexic.

Hayley also describes burning herself as a pressure release, a way of relieving suicidal feelings. Louise said that:

Cutting made me feel better for a while – it hurt so it felt like a strong thing to do, although I knew it was kind of stupid. It was a clear decision to do it, when I felt kind of powerless.

Lara, Naomi, Evelyn, Trisha, Rhonda, Jackie, Wendy and Jen all talked about cutting as a way of dealing with emotional pain.

Jen:

I was unable to express myself, the pain was like a physical ache. I felt raw, as if I'd been peeled. Cutting provided a release of

tension. A bigger physical pain made the emotional pain easier to bear.

Evelyn:

Cutting wasn't a suicide thing, it was a release of emotion. It does hurt, but it doesn't matter because you feel like you deserve to hurt. The internal pain is far worse than the physical. Sometimes cutting could be a way of dealing with feeling suicidal, releasing the pain instead of making a suicidal act.

Jackie:

I tried cutting myself on my arm to see what it would be like to cut my wrists, because I didn't want to fail at a suicide attempt [then I found that] cutting gave me a sense of release of tension, it changed my state... I began to cut myself in secret, just scratches at first.

Lara said there was no particular trigger to her burning:

It was a release of a gradual build up of emotional pain. The physical pain made it easier to cope. It felt like a normal thing for me, but other people's reactions made it feel like a sick thing, a mental thing. It was hard to give up, like giving up chocolate. Although it was painful, the pain didn't worry me at all.

Naomi made similar comments about the physical pain of cutting being easier to cope with than the emotional pain – it provided another focus, and:

It's a less damaging behaviour [than anorexia or suicide] because it doesn't hurt any-one else and there's no long-term effect. It also lasts longer, because I can examine the cuts as they heal and that takes two or three weeks.

Rhonda's description of the pain involved is different to most others. She moved on to cutting from bulimia:

I moved on to cutting with whatever I could get my hands on. I started to get my feelings back and my sense of pain so it hurt to cut, so I stopped and moved on to pills...they numbed the pain and made a distraction to whatever else was going on.

Cutting served a number of purposes for Wendy:

It was because of anger, frustration, inability to express my emotions. I had no-one safe to talk to, no-one would understand, I was ashamed, and I just wouldn't have been able to bring myself to talk. I hadn't even acknowledged the sexual abuse to myself - I kept a very tight lid on my thoughts – so how could I talk to anyone about it anyway? A few times I punched walls too. It was also about proving that I was tough, strong, leave me alone, do not fuck with me, no-one can hurt me. Which of course was bullshit. I didn't hurt because I didn't allow myself to feel... at the time I wouldn't have been able to say why I did it. Some-times it was quite public...I guess I was also wanting some-one to notice and try to help me, or just give me some attention, but at the time if any-one had asked what was wrong I probably would have said 'nothing'.

Trisha:

It was a beautiful sense of release, I felt peaceful afterwards, but it was bloody sore when it was healing, so I didn't do it very much. I felt mesmerised by the knife and the blood, and felt like I was getting a slice of power back.

Frequency of self-mutilation varied considerably among the participants. Some did it fewer than five times in total, while one did it an average of three times a day for several weeks. For some it was a short-lived behaviour, lasting less than a week; others have engaged in the behaviour for several years and continued to do so at the time of the interview.

In most cases, the self-mutilation began before the first suicide attempt, and nearly half continued after the last suicide attempt. In almost all cases the means used for self-mutilation were different from those used for suicidal behaviour: only two participants cut themselves as a form of self-mutilation and also cut their wrists in a suicide attempt. In every other case the behaviours were quite distinct, with most cutting themselves to release negative emotions, but taking overdoses to attempt suicide.

In summary, participants have used self-mutilation as a way of dealing with negative emotions, through changing the focus of their pain, reclaiming power over their bodies, and releasing tension. Some participants said that self-mutilation was a way of dealing with suicidal feelings. A wide range of emotions were associated with it; anger and frustration were the most commonly mentioned, but shame, guilt and a need to punish oneself and a desire to feel strong were also discussed.

Approximately one-third of the participants mentioned needing medical attention for cuts or burns. Although medical staff often initially accepted explanations that the injuries were the result of an accident, all participants who had treatment mentioned staff realising that they were self-inflicted injuries at some point. The reactions of the staff were varied. Some participants describe being scolded, several describe a lack of care on the part of staff (for example poor quality suturing or not being given anaesthetic). One participant was told how to cut her wrists “properly”, that is, to kill herself. Few seem to have been referred for counselling or other help. It is possible that staff were wary of reinforcing the behaviour by showing concern or sympathy. Indeed, Hayley said the best response was an unemotional, matter-of-fact one.

These precursors are in themselves indicators of distress; they may also be indicators of potential suicidality. Participants were involved in particularly harmful behaviours, disordered eating patterns, substance abuse and self-mutilation. Yet few participants mentioned receiving or being offered assistance to deal with these issues.

Cessation

Most participants found it difficult to articulate exactly why they stopped making suicide attempts. This was particularly the case for those who had made several attempts; generally those who made only one attempt were a little clearer on their reasons for not continuing.

This section begins by exploring the reasons given by participants, generally, for discontinuing suicidal behaviour. Various specific interventions that the participants had encountered are then examined, before moving on to explore the role of family and friends. Participants discussed other specific issues that should be addressed for

recovery to occur; these are explored next. Finally, participants' views of prevention are presented.

Although most participants made several suicide attempts, some, such as Anna and Jen, stopped at one:

Anna: "I had no thoughts of making another attempt, as the first didn't get me anywhere, plus I had to cope with my parents' reaction."

Jen:

It's hard to say why I didn't make another attempt. I was very annoyed when I woke up, but after a month [in hospital] I felt much better... At the end of the month I felt older and wiser – grown up. I felt that I'd taken control, and I could do it [attempt suicide] again if I needed to.

Of the fifteen participants who made repeated suicide attempts, a number of reasons were given for eventually stopping:

Richelle:

Although my foster parents tried to give me love and attention, I needed something more dramatic – a hospital, an ambulance... at some point I just stopped needing that attention... I realised that if I depend on some-one else to make me feel better then if they don't I'm in a pretty dire situation! The desire comes back in the same form, with the same instant need for help.

Richelle deals with this by going to the gym and exhausting herself. She is now aware that the feeling will only last for a couple of days, so she "just tries to live through it". Richelle has made many suicide attempts and cut herself many times, resulting in a number of hospitalisations; on some occasions she spent several months in psychiatric wards.

Wendy made two suicide attempts by overdose, both of which resulted in hospitalisation for several days. After taking the overdoses, Wendy had panicked at the thought of dying. On the first occasion she told her mother who took her to hospital, and on the second occasion she called her social worker:

[The second time] my stomach was pumped, and that was just horrific. By that time I was totally off my face and almost hallucinating and having that tube shoved down my throat was painful, terrifying... I was referred to a mental hospital for assessment, and that gave me a fright – I was afraid of going into a mental hospital, I was scared of the patients. My sister told me off for causing mum so much stress, and I felt it would be a bit pathetic to try a third time and not succeed. I wasn't sure that I wouldn't chicken out again, and no way did I want to have my stomach pumped again.

Louise:

I don't really know why I stopped making suicide attempts. I was scared – I wasn't sure that I wanted to die, and I'm a wimp with pain, and cutting my wrists hurt. I didn't make a conscious decision not to do it again though. I got another boyfriend which helped – it was the first time I had been in love, and it was wonderful. He didn't like drugs, so I stopped taking them. Things just got better. My parents got back together, and their relationship was much happier... I started making plans to go to university, and I was hanging out with different people. It was a combination of things, and feeling better about myself... I still think about suicide sometimes, but I'm pretty sure I won't try it again. I don't really know why I did it in the first place, so I can't say I definitely wouldn't do it again. I think about what my mother would do if I did it again – we get on really well now.

It is important here to make a distinction between cessation and recovery. Most participants continued to feel suicidal for some time after their last suicide attempt, but used other ways of coping, such as self-mutilation, drug use or utilising support networks.

Only one of the participants thought that having professional help was vital. This was Kate, who felt that her depression and anxiety was largely, if not completely, attributable to biochemical processes, and that anti-depressants were therefore a very

important part of her recovery. Although perhaps not essential, Jackie considers a particular type of help, Dialectical Behaviour Therapy, was a very important part of her recovery:

While I was in [a psychiatric unit], a nurse spoke to me about Dialectical Behaviour Therapy – a year long course, that was part of an experiment. I didn't think it would work, but I felt like I had no options. I'd previously done CBT [Cognitive Behavioural Therapy] a couple of years earlier, and it [CBT] helped a bit: I was able to stop cutting for a couple of months, but I wasn't given skills to replace it with, so when something went wrong I would go back to cutting. DBT's different; you learn skills as well as doing therapy... I really wanted to get better. I think it would have helped if I'd done it earlier, but there were three or four years when I didn't really care what happened to me, but for the previous couple of years I'd really wanted to get better. I'm still on meds, but DBT was 'it', and I feel like I've recovered, although I'm not finished the therapy and I still get really depressed some times. I can control my meds, and adjust them to suit ... I want to get off meds, I think I'll be able to.

Overall, the reasons participants gave for ceasing suicidal behaviour were varied, as were the forms of assistance received. While some found medication helpful, most did not; for others counselling was most beneficial and others identified support from family and friends, or becoming pregnant as key factors. The following sections discussed the various interventions and forms of support identified by participants.

Hospitalisation

Eleven of the participants were hospitalised for a suicide attempt. Most were admitted to an intensive or acute care unit, and then discharged. Five were subsequently admitted to psychiatric wards.

None of those who were admitted to psychiatric wards found it a particularly helpful experience. Two participants spoke of their time in psychiatric wards as providing

respite from the outside world; however, none reported any long-term benefit, and all except one discussed aversive treatment and negative consequences.

The aversive treatment mentioned included:

- not being given pain relief for suturing
- poor quality stitching (resulting in comments from the participants' usual doctor and/or unnecessarily extensive scarring)
- being scolded by staff
- being told to 'do it properly next time'
- being instructed how and where to cut in order to successfully commit suicide
- feeling that their problems were not as severe as other patients, with the result that they felt uncomfortable about their inability to cope

In addition, two participants mentioned meeting other young women in hospital and learning new self-harm techniques from them. Richelle has been hospitalised on several occasions, occasionally for both self-mutilation but more often for suicide attempts. Her first admission was for a suicide attempt. At that time she met a cutter, which was how she began to self-mutilate:

Being in hospital gave me ideas for other methods, and cutting. When admitted to the hospital psyc ward, I was labelled as having PTSD [Post-Traumatic Stress Disorder] and BPD [Borderline Personality Disorder] and being manipulative and attention-seeking. I was on constant medication for months, then put in mechanical restraints. I found this particularly difficult, as I had been locked up in dark places by my parents. I was placed in seclusion as punishment, which made things worse. I only wanted support and affection. Being alone and punished was the worst thing ever and made me feel so much worse about myself because of course in a way I had brought this horrible punishment on myself by 'acting out', as the staff put it. Medical staff gave me the sense that anyone with any other mental illness than BPD was sick and I wasn't because I was just manipulating. I found it too hard to ask to be admitted when I was suicidal and subsequently when I was feeling better, I asked staff to admit me against my will when I was suicidal. Some staff did that

but generally that didn't happen once I was under the care of the new psychiatrist. That made things very hard because I was suddenly left to my own devices as far as keeping myself safe. As much as I wanted to die I also didn't want to and I was suddenly only fighting against myself instead of staff who were committing me against my will! I had come to rely on being restrained as a tension release, and taking the choice away from me. Fighting with authorities about treatment externalised the problem – rather than battling with myself.

Kate:

After I'd been treated I was given the option of spending some time in the psych ward, which I did. I spent two weeks there, doing group counselling, which I hated. I felt like all my problems were minor in comparison to the other patients. It wasn't at all helpful, it just added to the stigma I was already feeling.

Trisha initially felt her hospital stay helpful:

It was bliss, I could relax there, I felt safe...for once I could set my hypervigilance to a low setting. [However], after six weeks I was told I wasn't clinically depressed, so there was nothing to treat, I should 'go back to what I had been doing'. I felt dismissed. I'd had a safe haven for a bit, but that's all. I was discharged to a counsellor, but that was a waste of time.

While Jackie identified aversive treatment, the attention she received seems to have reinforced the behaviour. Jackie said she wishes she had not got involved in the mental health service:

If I had had good support back when I was around 15 and things were just beginning to deteriorate the whole thing could have been nipped in the bud. Once I got hooked up in the service I began to rely on it, to have someone to talk to. If I'd stopped the behaviour I would have been abandoned. If the school counsellor had known more, but she just got scared by it. The first four years in the mental health service were a waste of time. Thinking 'I've got a mental illness' does not help.

Although not admitted to a psychiatric ward, Naomi was hospitalised on several occasions, and referred to the duty psychiatrist. She said it was not helpful because at that point she simply wanted to go home. In addition:

I had to see a different one [psychiatrist] each time, and they never seemed to have access to my notes, so I'd have to tell my story from the beginning each time, and that was upsetting too. Then I'd just end up going back to my same psychologist, so what was the point?

Robyn was hospitalised and had her stomach pumped, but was not admitted to the psychiatric ward. She said:

The hospital staff were unsympathetic and treated me as if I was wasting their time. I wasn't referred to counselling or any thing and I was told that the police might want to interview me, and that I'd have to pay for the ambulance.

In contrast, Jen's month-long experience of a psychiatric ward was positive:

I wasn't offered counselling or therapy other than occupational therapy, or medication. I spent my time doing artwork, which I've always found very therapeutic. I had the opportunity for a long rest, and was able to sleep better. I felt like nothing was expected of me. I was left to myself and was able to gather my strength – no pressures and complete rest. At the end of the month I felt older and wiser – grown up.

Overall, experiences of hospitalisation were negative. The one woman who did not have negative experiences, Jen, seems to have simply had the opportunity for a rest, without interventions or interference. Trisha's experience was initially positive for similar reasons, but this was marred by comments made when she was discharged (see above). No participants spoke of therapy or other interventions that were helpful.

Crisis Assessment Teams

Six participants mentioned contact with a Crisis Assessment (CAT) team. None of the participants spoke about the teams' services at any length. Generally the participants appeared to find the service satisfactory or useful, although Richelle mentioned that:

At one point I was ringing them every day. At first they responded straight away and tried hard to help, but after coming several times they refused to continue to [attend].

Naomi's experience was also mixed:

I was feeling suicidal and went to a friend who rang the CAT team. The person I talked to on the phone was really horrible, really mean, told me to snap out of it and to grow up. This just made me feel worse. On another occasion the people I lived with called the CAT team. The two men who came were really nice, and they gave me a sleeping pill."

Jackie described being verbally abused by CAT team members after calling them when she and a friend made a suicide attempt: "they called us fucking nutters and fucking retards".

Jackie had taken overdoses previously and found the CAT team to be helpful.

Psychiatrist/Psychologist/Counsellor

Fifteen participants had contact with a health service- based counsellor or other therapist (as opposed to a community-based service). Seven participants had contact with more than one psychiatrist, psychologist or other therapist; all participants felt that at least one of the professionals they saw in this context was unhelpful, and eight described it in terms that suggested that counselling or therapy had detrimental affects.

Jen discussed psychiatric treatment as a trigger to her suicide attempt:

I had one session with her [school-mate's psychiatrist], but I couldn't see how she could help. The headmistress was concerned about me, and sent me to see a different psychiatrist. He badgered me for details of my sex life. I knew this approach was completely wrong,

but I felt absolutely powerless. The day before a session with this psychiatrist I collected up all the pills I could find while the others were at evening chapel and took them.

Jen had been feeling powerless for a number of reasons. She was living in a boarding school, following her parents' deaths. During her holidays, the only place she could go was to her married sister's home, where she was sexually abused. The approach of this psychiatrist was "the final straw".

Richelle also discussed visits to a psychiatrist as precipitating suicidal behaviour:

I don't think counselling has had much of an impact. Counselling sessions with my first mental health worker, who did CBT, often led me to an attempt. I found it hard to talk to her although I liked her. I would dissociate and end up distraught. I'm now seeing a narrative therapist which is working better. It's very different; there are no safety measures, that's left up to me, to take responsibility, although that's a bit scary. It's non-blaming, and externalising: the past has led to my actions, in contrast to CBT which was really blaming, saying that all my actions have been my own choice.

Jen and Richelle's experiences are extreme; most participants spoke of contact with psychiatrists or psychologists as having no impact.

Sue: "The family did get a report from the hospital psychiatrist, but it didn't contain any useful advice. I never saw or heard from him again".

Reasons given for dissatisfaction were that the therapist did not seem interested, that the participant could not relate to the therapist because of age or gender, or that the participant either could not see the relevance of the questions being asked, or was uncomfortable with the therapists' questions or manner.

Wendy:

I was also referred to a hospital social worker. She was a middle-class, middle-aged woman and absolutely hopeless... she didn't have a clue what life was like for me. But then I also probably wasn't very good at communicating either.

Lara's experience seems standard:

The first counsellor I saw was a psychologist who made me tell him everything about the abuse although I didn't feel ready too. I was told to behave like an adult, and use the right words... His judgement of the abuse was that it was 'just kids playing'. After seeing him, I was so upset I vomited. The second counsellor I saw I persevered with for a year, but no progress was made – she didn't really get to the crux of anything. The third counsellor was a lesbian; I thought I would be able to relate to her. But she minimised my experiences, saying that 'others have been through much worse'. Counsellors always made me feel that they were the professionals and knew best whereas I was silly, weak, and 'born feeling blue'. The fourth and last counsellor was the one I was seeing before I was admitted to hospital, and I kept seeing him for another one and a half years afterwards. With him, everything 'clicked' although it took a long time to believe in him and develop trust.

Lara's experiences around disclosure of sexual abuse were echoed by Jackie, who described being pressured to disclose, "because if you cut yourself or have BPD everyone assumes you must have been sexually abused", and then being told that her abuse "didn't count." Jackie found disclosure very difficult, and to then have her experience minimised was very disempowering. She continues to feel pressured to discuss her experiences of abuse in her current therapy, but is not able to do so. Jackie has seen a number of psychologists, psychiatrists, crisis teams and counsellors and undertaken several therapies as well as having been hospitalised following suicide attempts and self-mutilation. Her experiences have been very mixed, ranging from being called "a fucking nutter" and "a fucking retard" by CAT team members to developing a supportive relationship with a psychiatric ward nurse. She is currently involved in a DBT programme which she is finding very helpful.

Medical staff

All but two of the participants had contact with a medical professional in relation to suicidal behaviour. Experiences with medical professionals, such as general practitioners (GPs), hospital emergency staff and nurses, were somewhat mixed. The majority had little to say about their experiences, while one commented that

“Emergency staff were really good – matter-of-fact. Sympathetic without making a fuss.” Four participants criticised their GP for simply giving them anti-depressants, with no offer of a referral to counselling or other follow-up care; the apparent expectation was that medication would ‘solve the problem’. Six participants have used anti-depressants or other medication prescribed in relation to feeling suicidal to commit suicide attempts.

While in some cases it appears that participants were not particularly proactive in seeking additional help, it should be remembered that many participants reported loss of self-esteem, shyness and feelings of helplessness that may combine with the loss of self-motivation characteristic of depression to render the individual incapable of extended efforts to seek assistance.

Wendy:

I asked the doctor [at the alcohol and drug centre] to admit me to a residential facility, but he said I didn’t seem to need it... I wanted to be in a residential facility because I was struggling to cope with my emotions, but I wasn’t able to explain that. He would of asked why I felt like that, and I couldn’t answer without talking about the abuse. So I couldn’t say anything.

Five participants spoke of difficulty in approaching the family GP. Lucy:

I felt ashamed and embarrassed. I couldn’t explain, I felt stupid, like my reasons were petty and didn’t make sense. The family doctor was in his 60s, and hard to talk to. I had gone to see a female doctor earlier, but I couldn’t bring myself to talk to her. She seemed very clinical and unapproachable.

Although Trisha did speak to her family GP about the sexual and physical abuse she was suffering at the hands of her father “He questioned the accuracy of what I was saying, which was quite devastating. It took every last drop of courage to tell him, and then he didn’t believe me.”

The overall impression is that the family doctors of these women were ill-equipped to deal with the issues that they were presenting with.

Medication

Twelve participants were prescribed medication for depression or anxiety, in most cases before the first suicide attempt. All but one of the participants were unenthusiastic about the effects of medication. The one who was unequivocal about the benefits of medication was the one participant who felt her depression was caused solely by biochemistry.

Of the remaining eleven, comments largely fell into three categories:

Medication 'took the edge off' their depression, but did nothing to deal with the underlying causes, so was perceived to be of limited benefit;

Medication had no effect;

Medication had negative consequences.

Comments regarding negative consequences were usually about side effects. Heidi remarked that she felt pressured to take medication, although it made her feel worse, and the resultant grogginess affected her ability to do her schoolwork and her relationships with her friends. Other side effects mentioned included weight gain, personality changes such as increased aggressiveness, decreased sexual response, and anxiety.

Jackie:

Although the mood stabilisers have helped, other meds probably weren't trialled for long enough. This might be partly my fault because I was always impatient for it to work, and found it hard to wait for the six weeks or whatever for it to take affect. I had some bulimic tendencies, and the Arapax helped with that.

Four participants remarked that their doctors seemed to feel that the only or most appropriate treatment was medication, and once that had been supplied no further action was required. Two participants noted that not only did medication alone do nothing to deal with the underlying causes, it actually slowed down the process of counselling.

Perhaps the negative responses to medication are unsurprising in the cases of those who tried medication before they engaged in suicidal behaviour. If the medication had been effective, the participants may not have made suicide attempts; the majority of people may find medication effective and not go on to engage in suicidal behaviour and therefore would not have been included in this study, which may only include the minority of women who do not find medication helpful and go on to attempt suicide.

All but one of the participants who were prescribed medication for depression before their first suicide attempt subsequently used it to overdose. Several participants remarked that they were surprised that they continued to be prescribed potentially lethal quantities of medication after they had made suicide attempts.

Child, Youth and Family Service

It would appear from the high number of participants with a history of abuse within the family that many would have had contact with the Child, Youth and Family Service (CYFS). However, only two participants specifically mentioned the service, and both of those made negative comments:

Trisha:

I went to DSW [the Department of Social Welfare, the predecessor of CYFS] to ask for help with my son. He has ADHD and I was struggling to remain a safe and positive parent for him because I was utterly exhausted. I was coerced into signing a form admitting to being an unfit mother in order to get an agreement for respite care.

Wendy:

There were various people who could have stepped in along the line. In fact you could say it was their job to, for some. I saw two different social workers from DSW when I was around 15 or 16. The first one, a young guy, came to our house. That was the first time I'd met him, and we met in the lounge, with Mum and Dad there. He asked something like 'are things ok at home?'. Well, how was I supposed to answer that, with Dad sitting there watching me? I just

said 'I guess so', and that was it, pretty much. The second one was a middle-aged woman, and she just looked at me and treated me like a piece of shit. It was after I'd run away from home and it just never entered her head that there might have been a reason for it, other than me being a trouble-maker.

Despite these negative experiences, the lack of comments on CYFS may have been due to general satisfaction with their services. For example, Richelle mentions her foster parents, which suggested that she had contact with CYFS. It may be that negative experiences are considered more note-worthy. It may also be relevant that both Trisha and Wendy are recounting experiences that happened over ten years ago; the service may have improved since.

Community Organisations

Support groups. Four participants spoke of taking part in support groups – one for self-mutilators, one for depression, one for anorexics, and one for incest survivors. While the participant considered the latter group very beneficial, participants in the former two groups both felt that any benefits were outweighed by disadvantages. For example, if one member of the group 'relapsed' it had a demoralising effect on the others, often having a 'domino' consequence. In addition, group members learnt new ways of harming or starving themselves, and new ways of hiding it.

Counsellors (community-based). Counselling with community-based organisations seems to have been more effective than with therapists working in the medical system, although the participants' perceptions were still mixed. Thirteen participants had sessions with at least one counsellor; organisations ranged from Rape Crisis to Christian counselling services. Only two participants reported that the first counsellor they saw was helpful. Six participants persevered and consulted other counsellors.

Of the eleven participants who were dissatisfied with the first counsellor they consulted, the majority simply found the experience to be ineffective. Three found the experience to be actually detrimental:

Louise:

I was referred to a counsellor by the school guidance counsellor. It was a disaster. Her own daughter had recently committed suicide, and she was just really angry and critical of us [Louise attended the counselling session with a friend who had made suicide attempts with her]. Every-one was crying, it was just terrible. There was no follow-up, nothing helpful came out of it at all.

Neither Louise nor her friend have seen a counsellor since.

Hayley:

My friends went to the school counsellor, because they were worried about me, and because my younger sister had told them she was worried. The school guidance counsellor told me that he was going to see my parents. I asked him not to, but he insisted. I didn't go home that evening until hours after he had left. My parents never said anything about it, but I felt betrayed, and it took me a long time to be able to develop trust in a counsellor as a result. I didn't see him again. He also referred me on to an eating disorder service, who I also didn't feel happy with. I only went there once, having been more or less forced to by the school counsellor, and I was just referred on to the hospital. I felt out of control, like I was being kicked around like a football.

While most participants who had therapy or counselling began with a hospital referral and ended up with a community counsellor, Wendy went full circle:

I saw the school counsellor, but I'd been sent there for bad behaviour, so her attitude towards me was really negative. She had no interest in why my behaviour was bad, just in punishing me... Years later I saw a hypnotherapist [in the interim having had some counselling with a hospital social worker and at a drug and alcohol centre, discussed above]. [The hypnotherapist] was a complete charlatan. She just dredged up all this stuff from my past over the course of one session, the first time I met her, then just left me to get on with it. I tried a few 'new age' type therapies, none of which were any help, at least not for more than a day or two, and often left me feeling as if I was to blame – it was my karma.

Eventually I saw a clinical psychologist, which did help; I finally got to put some stuff in perspective and stopped blaming myself. All this was over the period of about 15 years...It took a long time to get to a place where I was able to get past the shame and talk about the important stuff, and an equally long time to find some-one trustworthy, who I didn't feel was judging me, who would believe me.

Reasons given for feeling counselling was not useful were mainly about not feeling able to engage with the counsellor due to, for example, age or gender differences. In some cases the counsellors' approaches were questioned:

Heidi:

I went to counselling for 10 years, it never helped. The counsellors were changed often, sometimes at really short notice, and I spent a lot of time filling in questionnaires. When I was 16 I stopped going a lot of the time. The counsellor I had then said I had formed an unhealthy attachment to him and started questioning my sexuality and motivations.

Trisha:

The counsellor I saw after I got out of hospital wasn't much help. We didn't get on, so I stopped going. She saw everything in black and white, and was very challenging. At the time I didn't really know what was going on, but now I would seriously question her methods.

In other cases the participants' simply did not feel ready to talk, particularly where disclosure of sexual abuse was part of the problem. Tracey: "The doctor referred me for counselling, but I only went 2 or 3 times because I didn't feel ready, and I didn't want any-one to know what had happened to me."

Wendy:

The counsellor I was seeing was easy to get on with and understanding, and seemed to be interested in underlying problems,

but I never got close to telling him about what had happened – I wouldn't have even admitted it to myself at that point.

Conversely, Trisha describes why Rape Crisis was helpful:

I was validated and told the choices I had made were good choices, as they had enabled me to survive. They provided unconditional acceptance, and affirm your courage, value and recognise your achievements. You're invited to talk, but there is no pressure - you set the pace. They help you develop support networks and coping strategies and look at your physical well-being, not just psychological.

Kate began counselling some years after her suicide attempt, which she found very helpful:

Especially in regard to information I was given on physical responses to anxiety and panic, and skills such as relaxation techniques, breathing exercises, recognising the warning signs before things go too far.

She also noted that: "There are lots of shonky ones that make things worse. It's just a matter of luck really, whether you get a good one."

Seven participants also spoke about an apparent lack of counselling or support for their family or friends. This appeared to be an issue of particular importance in cases where sexual abuse perpetrated by another family member (especially a grandfather) was disclosed. As mentioned elsewhere, in some cases the family member who abused the participant had also abused the participant's mother, adding an additional burden of guilt or shame to the mother's concern for her daughter.

Family

Family reactions to suicidal behaviour ranged from intense concern to anger to embarrassment:

Hayley:

My mum attended two meetings at the hospital, but my dad told her off for going and wouldn't let her go again. He said I just needed to

pull my socks up... It's really hard to work on your problems when your family deny they exist.

Lara:

My family was shocked by me being admitted to hospital. My brother was really angry and only visited once... My mother's been really supportive, I don't know how I would have coped without her, and it's been really hard for her, to carry that burden.

Jackie:

The hospital called my parents [after an overdose], who did nothing – they didn't talk about what I'd done, just bought McDonalds – which was something they never did. They didn't give a damn.... After I was released from hospital [from another overdose] I went away with my parents. Although they did talk about the OD a little, they mostly talked about how they would have sued the hospital over the head injury if I'd died, not about why I did it, or what they could do to help [Jackie sustained a head injury while in hospital]. This holiday was supposed to be for a week, but after one night I had a sort of panic attack and was admitted to hospital...

Although the participants' family knew of the suicidal behaviour in almost every case, in eight cases the behaviour has never been discussed. Four participants spoke of their parents' initial reaction being one of anger, particularly on the part of their father, followed by never raising the topic again. Lucy's experience seems typical of these responses: "It was never discussed with my parents – they would just be angry, although I think my mother has been depressed. My family's quite weird – we don't really talk about things."

Jen: "I've never talked to anyone about it, except my husband, years later."

The importance of therapy or support for family members was stressed by most of the participants. A number of participants discussed the lack of support available for family members, noting that this was particularly an issue for the parents of those

who had been sexually abused. Three participants mentioned their father's difficulty in coping with his anger:

Tracey:

Dad ended up on Prozac. At first I was worried that he was going to take things into his own hands. In some ways I wanted him to, but I was scared he would end up in jail. He still gets really furious when he hears about any-one being abused, even just on TV.

Several participants spoke of a chain reaction to disclosure of sexual abuse, with other family members subsequently disclosing their own experiences of abuse, and other family members struggling to cope with the information:

Tracey:

My brother stopped speaking to me because he'd been close to my grandfather and he refused to believe it [that Tracey's grandfather had sexually abused her]. Although things are better between us now, and he does believe it, partly because of Mum and my aunt disclosing too. Now he feels bad for not protecting me.

Friends

The impact of friends in cessation has been very mixed. A number of participants spoke about friends encouraging them to seek help, while other participants spoke of the reaction of friends being a key turning point:

Tracey:

Only my best friend stuck by me, but she was great – very supportive, and there for me. After the suicide attempt she confronted me, saying that I had scared her, and that I must never do it again. She got me to help with her baby, which helped... I really want to be a mother, and I knew I couldn't be a good mother if I didn't get over it.

Sue: "My best friend confronted me after I was discharged, and told me she was worried and upset with me. I made a promise to her that I won't attempt suicide again."

Lucy:

I was able to talk to my friend Judy. Judy should be a counsellor – she was very easy to talk to, non-judgemental, plus she was outside the family. I hadn't [previously] been very close to her, but we became close, and I also became close to her mum, Kylie, and her support meant a lot because I had been quite intimidated by her. Judy and her mother were being nice, honest and genuine, which was important – I didn't want pity, I just needed genuinely nice people around. If I hadn't had Judy and Kylie to talk to it would have taken a lot longer to recover. They didn't judge me, they just listened to me.

Wendy also speaks about the mother of a friend becoming a key support immediately after her suicide attempt:

I was embarrassed by my suicide attempts and didn't talk about it, except for the mother of the friend I'd rung during my second attempt. She became a close friend, and she was a huge support. I felt like she cared about me. I began to call her 'Mum' and she was always there for me. I could ring her anytime or go and visit and talk about anything. She never judged me and told me how she had suffered from depression, and how she got through it.

It appears that prior to the suicide attempt these women felt they had no-one they could talk to, but the attempt opened communication channels. For others however, friends were a part of the problem:

Louise:

I twice took overdoses with a friend. We were both drunk, and had got into a pattern of talking about our problems and depressing each other. The fact that we were drunk was probably what saved us, because that was what made us sick. Another time we cut our wrists... The only person I ever talked about the suicide attempts with was the one who was actively involved in them, and we just fed off each other. Other friends never brought it up.

For some participants social isolation and a lack of friends was a key issue.

Control

Many participants spoke about gaining a sense of control as an important part of their recovery from feeling suicidal. For most this was a sense of control of their emotions:

Richelle:

I developed my own safety plan. It was too hard to say when I was feeling suicidal, so I developed a code with different colours, like an asthma management plan. Different colours represented different feelings or actions, so I could just say the colour. My management plan explained how I wanted to be treated when I was suicidal or self-harming.

Evelyn discussed learning not to 'horrorilise' her problems: "Now I can think more rationally, and realise why I'm feeling down, and what to do about it, before I get in too deep."

Maree:

I used to try to get it together and not be able to, and made myself wrong all the time...I realised I had to take responsibility for myself and people wouldn't always be there to make me feel better – I had to do it. Both of the counsellors that I consider made a difference for me were pretty firm, putting my feelings back onto me and having me take responsibility.

For others it was recognising where the source of their problems lay:

Sue: "I also got a sense of control when I testified against my abuser. He had taken my power away, but now he's in jail and I've got some power back".

Jane:

I realised that my parents were the source of my problems and I decided I wasn't going to let them beat me. At some point I realised

I could affect the world, and I felt a sense of control. Knowing where it comes from makes it easier to deal with; now I know my triggers, and what to do.

Trisha, referring to sexual abuse:

Reclaiming what was taken was important. With the help of Rape Crisis I confronted my father, and the doctor that didn't believe me...I've realised it's ok to be miserable, that it will pass, and there's a better life ahead.

Issues of power and control were important in relationships with counsellors and therapists. For example, Jen spoke of feeling powerless to complain about a psychiatrist's inappropriate approach to therapy because she was being sent by her boarding school; Hayley discussed being "kicked around like a football" between services, and her school counsellor discussing her problems with her parents, despite Hayley asking him not to. Jackie and Lara spoke of feeling like the therapist was the expert and they were "just" the patient, or as Jackie put it, that "you're not an individual, you're a disorder".

In contrast, several participants discussed eventually finding a counsellor that they were able to work with. These effective therapeutic relationships seemed to be characterised by an equal partnership, with participation in the process of therapy, such as choosing when and how to disclose abuse.

Self-esteem

A lack of self-esteem was discussed by most of the participants as being a factor contributing to their suicidal behaviour. Therefore, it seems logical that building up self-esteem was an important part of recovery. This was borne out by participants' comments:

Collette: "Travelling helped too. I hadn't had any direction and going to Australia increased my confidence and independence."

Robyn:

Getting a job helped because it allowed me to develop a new social circle independent of my boyfriend. My work-mates realised I was in need of some nurturing, and they gave me lots of affection and support, and I started to feel a bit better about myself. They are probably the reason I didn't make another attempt.

In addition to self-esteem issues that lead to becoming suicidal initially, many participants spoke about their suicidal behaviour being a further source of feelings of inadequacy.

Jane: "I still feel a lot of guilt for being weak and inadequate."

Lara: "I've been left with a feeling of 'you are a mad person' - I sometimes felt like I was being humoured, and that was hurtful."

Richelle:

[Hospital staff] gave me the feeling that anyone with any other mental illness was sick... and I wasn't because I was just manipulating...I felt like I had to apologise when I was getting my cuts stitched.

Connections

Developing personal relationships and feeling connected to others was an important factor in cessation. A number of participants mentioned meeting a new partner, or getting pregnant as being key determinants in ending their suicidal behaviour. For others, forming connections with new friends or workmates was important, while for some developing a deeper relationship with existing friends or relatives was the source of the feeling of connection; in the latter case, this has come about as a result of the suicide attempt. The key feature seems to be feeling valued, and believing they had some-one trustworthy in their lives.

Heidi:

I got pregnant, and that was the final turning point. I realised that I couldn't muck up my son's life, so I made some decisions. I got another counsellor and committed to doing work.

Evelyn: “After my suicide attempt Mum and me talked. It didn’t solve anything, but it did make me realise that Mum needed me, and I couldn’t do it to her.”

Religion

While a number of participants identified religion as being a factor in becoming suicidal, five participants mentioned religious or spiritual beliefs as a factor aiding their recovery. Evelyn and Wendy both spoke about fear of death, based on uncertainty as to whether it really would be ‘the end’:

Evelyn:

I was also concerned about the spiritual consequences of killing myself, in terms of karma and going to hell. I wasn’t sure that I believed in either, but in the end I wasn’t prepared to take the risk

Trisha, Heidi and Patti mentioned faith in God as a help in getting through the challenging times.

Stigma

Most participants spoke about the stigma attached to suicidal and self-harming behaviour. For example, Richelle spoke about the difficulty in coming up with an appropriate answer when people asked her how she got the scars on her arms, and the negative reactions of people when she has told the truth, although Maree said that while there is a stigma, many of her friends have been in similar situations and can understand why she did it.

Jackie spoke about issues around stigma and having a mental health diagnosis at length:

People’s reactions [family and friends who know about her cutting and overdoses] have been an issue. When I was hospitalised a nurse rang my parents. I knew they had been contacted, but they said nothing about it... My sister came to see me in hospital but freaked out and didn’t come back... My parents were afraid that I’d hurt them or my little brother and said they couldn’t sleep with me in the

house. That was really hurtful – they made no attempt to understand or find out about what was going on. I've told a few friends, but they've usually reacted badly. They may appear understanding to your face, but then talk about you behind your back like you're a freak. Even professionals don't get it, treating you like you're just attention-seeking and manipulative, so much so that you don't want to ask for help although you need help and you're not coping. You believe the label. When you get a diagnosis it's horrible [Jackie has been diagnosed with BPD and dysthymia]... I've read the literature and it's horrible... Every one I know with the label hates it. You still have the label for years afterwards, the only good thing is that to get into DBT [a type of therapy that Jackie found very helpful] you have to have BPD. You're not an individual any more, it's just 'This is how we treat the label'.

For some stigma was an influencing factor in deciding not to attempt suicide or self-mutilate again:

Anna:

The biggest lesson was about the impact a suicide attempt has on the people around you; an attitude of 'she's a bit mental, a bit of a loser, you have to be careful around her'. People definitely judge you on it.

Lara:

I tried to stop doing it when other people found out about my cutting and challenged me. I realised it was hard for people to cope with, but it [cutting and burning] felt normal for me. Other people's reactions made it feel like a sick thing, a mental thing.

Lucy:

I knew someone who had been in hospital for depression, and there's so much pity around it, people think you're weak. You know you're weak... I felt ashamed and embarrassed [when her sister caught her in the middle of a suicide attempt]... I felt like a head-case when the family doctor talked about putting me on anti-depressants. Taking medication would be like admitting that there's something wrong mentally – that's a terrifying thing. You don't want to believe you've got a mental problem: it's easier to believe you're a bad person or

stupid than you've got a screw loose. People would look at you sideways if they knew.

Patricia: "growing up I knew older people who had committed suicide and I thought they were nuts" – but this obviously was not a protective factor for Patricia.

Tracey has little contact with friends from that time: "it feels awkward if I see them; they just stopped making contact with me. I'd walk into the pub and people would start whispering about me."

Jen:

I've never talked to anyone about it, except my husband. I told my sister I was going to take part in this research and she just squirmed with discomfort. I'm still very sensitive to words like 'crazy' even if they're said as a joke.

It has been over 20 years since Jen's suicide attempt.

Two participants, Kate and Lucy, mentioned the 'Like minds like mine' television campaign, featuring well-known New Zealanders who have mental illnesses. Both felt that the campaign was a positive step toward dealing with stigma, and improved their own self-esteem.

Lucy:

Who would have thought that John Kirwan had depression – if a rugby player like him can get it any-one can... I wish I'd known that before, I wouldn't have felt like I was mental and so alone.

All the participants talked about feeling embarrassed or ashamed of their suicidal behaviour or mental illness. Four participants had never spoken about their suicide attempt(s) at all, and more than half had never spoken to their family about it, even in cases where the family knew. Presumably this has implications for seeking help, and dealing with being diagnosed with a mental illness.

Prevention

Many of the factors discussed in regards to intervention may be appropriate as forms of prevention, if at risk young women were identified. Many participants had sought professional help before they attempted suicide; as discussed above, several were put on anti-depressants while others had sought help from counsellors. Some, however, such as Louise, Robyn, Evelyn and Jen, got through this period without assistance from others. For Jen, the suicide attempt provided the sense of control she needed – she had an ‘escape route’ if she needed it; for Louise, a number of small changes such as taking charge of her academic progress, making new friends and starting a new relationship contributed to increased self-esteem; Robyn and Evelyn talked about similar processes of empowerment. A key feature for all participants was building self-esteem through empowerment; feeling that they were in control of their lives.

Only one of the participants thought that having professional help was vital. This one was Kate, who felt that her depression and anxiety was largely, if not completely, attributable to biochemical processes, and that anti-depressants were therefore a very important part of her recovery.

Advice for family and friends

When asked what advice they would give to family or friends of young women who seem to be at risk of suicidal behaviour, a number of key themes emerged that can be arranged into groups:

- **Build self-esteem**

Do little things to demonstrate they are important and valued – acknowledge their gifts and talents, tell them why they are a worthwhile person.

Give physical affection if it seems to be wanted - but be aware that it might not be.

Work with them to develop some strategies to give them control: things to do to lift the mood, such as going to a movie.

- **Communicate**

Ease into talking gradually – let them set the pace.

You may need to be proactive – you cannot necessarily wait for her to start the conversation. Say something like “I can see that there’s something wrong, and I need you to let me help”. Find a balance between opening communication channels and being pushy.

Maybe you are not the right person for her to talk to. That is not a reflection on you, and make sure she has got some one else.

Listen, let them do the talking, do not interrupt.

Do not judge.

Take them seriously, do not minimise their feelings and experiences.

Consider sharing your own experiences, and how you got over difficult times.

Let them know they are normal, not a freak, lots of people have been through what they have been through.

Acknowledge that yes, it is tough, but you know they can get past it.

- Practical solutions

Deal with the underlying issues - but let them decide how to deal with it. Do not coerce them into pressing charges against an abuser, for instance. Encourage them to take control of the situation.

Take care of the triggers – work out ways to deal with the fight with the boyfriend, for example – but do not forget the underlying issues.

Do not let her sit and brood – do something physical, go for a walk.

Try to keep some normalcy in her life; get her up at a reasonable time, encourage her to have a shower, go about day-to-day life.

Have a bath with some nice oils, play uplifting music.

Give them something to live for, something practical, make them feel needed – a pet for example, or a part-time job, or just helping around the house.

Develop a safety plan to afford a sense of control. If she starts to feel down, she should already have some ways of dealing with it.

Tell them clearly that it is not ok to harm themselves, tell them you need them and you treasure the relationship.

Remember that it is hard to see the big picture, so concentrate on little day-to-day things.

This concludes the presentation of the findings of participant interviews. The next chapter, Chapter Seven, discusses these findings with reference to relevant literature.

CHAPTER SEVEN: DISCUSSION

Chapters Four, Five and Six presented the results of the research with key informants and women who had engaged in suicidal behaviour respectively. This chapter explores the key findings with reference to the literature. The chapter begins with a discussion of the Component One findings, working from risk factors through cessation to prevention. The same format is then followed for the discussion of the Component Two findings, with the addition of a summary of the quantitative data regarding the behaviour engaged in, and a discussion of participants' views of the behaviour itself. Finally, the information gleaned from the two participant groups is compared and contrasted. The chapter concludes with a pair of tables summarising the key factors in suicidal behaviour as viewed by the two participant groups.

Component One Findings

Component One of the research collected data from key informants: counsellors, clinicians, mental health workers and others who work with young suicidal women. Chapter Three has provided a detailed description of the informants, and the interview guide is attached as Appendix Three.

Risk Factors

The current view of suicidal behaviour is that in most cases a complex interaction between risk factors exists, composed of a reciprocal relationship between the individual and her environment (van Heeringen, Hawton and Williams, 2000). The current model of suicidal behaviour is that in most cases several risk factors combine to result in suicidality. This model was largely reflected in the key informant interviews, although there was disagreement over the importance of some factors.

Psychopathology

Clinicians and health service workers tended to stress psychopathology over other risk factors, while the reverse was the case for community-based workers. Whereas health service workers spoke of disorders first and foremost, community workers spoke of social factors and life events leading to emotional distress. Notwithstanding

this differing focus on pathology, all informants agreed that young women who engage in suicidal behaviour are usually depressed, and some may be severely stressed or anxious. This perception is in accordance with local research (Barwick, 1992; Beautrais, 1996).

Social Factors

Almost all informants also discussed social factors that they believed contributed to suicidal behaviour. Many informants spoke of culture as a contributing factor. This can be divided into two broad categories; youth culture and ethnicity-based culture.

Youth Culture

The aspect of youth culture that was most commonly identified was music choices and the accompanying life-styles. 'Metal' and 'rap' music were identified as the most influential in relation to suicidal behaviour; informants noted the prevalence of lyrics about death and violence, and suggested that vulnerable young people adopted the attitudes and mores portrayed in this music. As discussed in Chapter Two, although linkages between music choices and suicidality have been the topic of public discussion, there has been relatively little research conducted. Most of the research that has been carried out has focused on heavy metal music (Stack, 1998). While heavy metal music fans do appear to have higher rates of depression, lower self-esteem and other risk factors for suicide (Scheel & Westfield, 1999), as yet there is no clear finding that this relationship is causal; rather, it may be that this type of music appeals to young people who are already depressed and/or at risk of suicidality. Ballard and Coates' (1995) study of the effects of both heavy metal and rap music failed to find evidence that lyrics or music type has an immediate effect on anxiety, self-esteem or suicidality in a sample of young people who were not necessarily fans of these types of music, despite explicitly suicidal lyrics. However, Ballard and Coates' study did not test the possibility that listening to this music has a cumulative effect. The overall finding from reviewing the research on this topic is that although young people who listen to metal and rap music may be more at risk of suicide than other young people, this is due to external factors rather than the music itself. Further, Lacourse, Claes and Villeneuve's research (2001) found that young females' choice of and response to heavy metal music was different to boys': listening to this

music appears to lessen the risk of suicidal behaviour for young women, but not for young men.

Ethnicity

Informants' views on the importance of ethnicity as a risk factor varied from believing that it had no relevance at all through to arguing that the long-term effects of colonisation continued to impact the rates of Maori youth suicidal behaviour, and the pressures of being an ethnicity other than European in New Zealand society contributed to suicidal behaviour in Pacific Island peoples also. In the main, informants felt that members of some ethnicities, notably Maori and Pacific Island, were more likely to be poor and this increased their risk of exposure to risk factors for depression and stress, such as lack of access to health services and other resources, lack of educational opportunities and overcrowded living situations. Several informants discussed a feeling of alienation from their whakapapa as an underlying cause of Maori youth feeling disconnected, not valued, and lacking self-esteem. This argument fits with that of Langford, Ritchie and Ritchie (1998), Lawson-Te Aho (1998) and Tiatia (2001) who have argued that there is a link between colonisation, deculturation and suicidal behaviour.

Gender

Several informants did not feel that there was a difference in risk factors for young women and young men; the difference in rates of suicidal behaviour may solely be accounted for by differing methods. Interestingly, all the informants who held this view worked from a medical model. Other informants' comments on gender differences in risk factors were limited to suggesting that sexual abuse may be a more common factor among young women, and schooling difficulties more common among young men. The argument that young men are more likely to become distressed over academic failure has some support in the research literature (see Vanatta, 1997, for example), but findings are inconclusive. However, some informants noted differences in coping mechanisms.

It was suggested by informants that young women are more likely than young men to have close friends with whom they can discuss personal problems; this may have the result of delaying or preventing suicidal behaviour. Additionally, some informants

felt that young men were more likely to engage in behaviour that drew attention before becoming actively suicidal, whereas young women are more likely to become socially withdrawn and therefore not obtain help. However, this perspective was by no means universal: several informants felt that both young men and young women may go through a period of 'acting out' and overt risk-taking before developing into the more expected social withdrawal. This discussion of externalising and internalising behaviours is expanded below. In short, although some informants did feel that there are gender-differentiated patterns of behaviour, there was no agreement on what these behaviour patterns are.

While it has been established that young men and young women who come to the attention of medical authorities for suicidal behaviour differ in regards to choice of means, it is my suggestion that risk factors for young women and young men may differ also. This argument is supported to some extent by the literature on gender as discussed in Chapter Two. Briefly, research suggested that depression and low self-esteem are more common in adolescent girls than boys (Debold, 1999), being female is a risk factor for suicidal behaviour, even when depression is controlled for (Lewinsohn, 1993), girls are subject to more risk factors than boys, and the impact of risk factors common to both genders is greater among young women (Langhinrichsen-Rohling et al., 1998). However gender differences in suicidal behaviour have largely been overlooked, particularly in New Zealand. The opinions of the informants in this regard were mixed, but in total seemed to support the idea that sexual abuse is a more common risk factor for females than males. It may be, however, that males are more reluctant to disclose sexual abuse than females.

Overall, although there is some evidence that points to gender being an issue in suicidal behaviour, the psychological and psychiatric literature tends to ignore gender. This omission was also seen in the Component One interviews.

Family Environment

All informants considered that a negative family environment was a factor in the majority of cases. In addition to abuse and neglect, which are discussed below, informants considered that negative family situations that could increase the likelihood of suicidal behaviour included poor parenting, a lack of connectedness

within the family, isolation from biological parents, financial stress or parental substance abuse, all of which are discussed in the literature and are summarised in Chapter Two (Brent, Bride, Johnson & Connolly, 1996; Smith, 2001). As Hollis (1996) has found, family discord and a lack of warmth at levels less than what would normally be considered neglectful or abusive are associated with suicidal behaviour. Slap, Goodman and Huang (2001) argued that a lack of family connectedness is more common in families with adopted children than in other families, resulting in increased suicide rates in adopted teenagers.

Abuse and Neglect

An association between abuse and neglect and suicidal behaviour has been clearly established by previous research and was discussed in Chapter Two. Component Two informants discussed this link at length. As noted by informants in the current study, neglect and abuse tend to go hand in hand. Research has tended to focus on sexual and physical abuse, with neglect taking second place, yet recent research such as that by Gibb and colleagues (2001), Lipschitz and colleagues (1999) and Thompson, Kaslow, Bradshaw-Lane, and Kingere (2000) suggested that emotional abuse and neglect appear to be at least as important, perhaps because of negative judgements that accompany emotional abuse leading more directly to a lack of self-esteem than physical or sexual abuse alone. These findings are supported by the current study, in which several informants spoke of the depression attributed to the emotional unavailability of caregivers. However, while the importance of emotional abuse and neglect was clearly identified, a greater focus was given to sexual abuse.

Informants generally agreed that sexual abuse is a very common factor underlying young women's suicidal behaviour. At the same time, several informants felt that the way the abuse was dealt with was very important; the impact of sexual abuse could be moderated by counselling and/or good support. A difficulty, according to informants, is that young women frequently find it difficult to seek help for this abuse. Some informants lamented the delay between abuse occurring and being disclosed, and the concomitant delay in getting help to deal with the abuse. Another suggested that it was not necessary to wait for disclosure, that it was possible for a clinician to ask clients. As Muir (1993, 2001) discussed, the delay of disclosure of

sexual abuse is not uncommon, often due to feelings of guilt or shame, or the lack of an appropriate person to disclose to.

Substance abuse

The use of alcohol and other drugs, particularly cannabis, was discussed both as a risk factor in itself, and as a way of self-medicating, to deal with negative emotions caused by other factors. In some cases parental substance abuse was also an issue. Local research such as that of Beautrais (1997) reported that those individuals who met DSM criteria for cannabis abuse were ten times more likely to make a medically serious suicide attempt than those who did not use cannabis to this extent. Beautrais, Joyce and Mulder (1994) found that approximately half of young people who engaged in suicidal behaviour had substance abuse histories, but substance abuse may not be a risk factor in itself. Rather, as several informants in the current study suggested, cannabis is more likely to be used by those who are at risk of suicidal behaviour, in a correlated rather than causal relationship. Some of the factors that underlie substance abuse may also lead to suicidal behaviour.

Relationships

The demise of a relationship was considered to be a frequent trigger for suicide attempts, which is unsurprising given Beautrais' (1997) finding of relationship break-up precipitating approximately a quarter of medically serious suicide attempts³².

In conclusion, informants identified a number of risk factors for suicidal behaviour, most of which are in accordance with the literature. The psychiatric and to a lesser extent psychological literature tends to emphasise psychopathology; this perspective was also found among those informants working in the mental health. Overall the literature explores a range of contributing social factors, many of which were also acknowledged by all informants, some seeing these factors as more important than others. The emphasis on ethnicity given by some informants, while not universal, is

³² Beautrais' definition of a 'medically serious suicide attempt' is discussed in Chapter Two. Briefly, it is an attempt which requires hospital admission for at least 24 hours *and* meets other criteria such as a high risk of fatality such as gunshot or hanging or requiring specialised treatment.

stronger than that given in the local literature that, with a few exceptions, tends to ignore this issue.

Cessation/Recovery

The difference in the perspectives of informants who worked in the community and those who worked in the mental health service extended into views of requirements for recovery. While the former were largely unconcerned with diagnoses and focussed on dealing with underlying issues, only occasionally with the aid of medication, the reverse was often (though not always) the case in the latter group.

Aside from prescribing appropriate medication, most informants' interventions tended to focus on addressing deficits such as a lack of self-esteem, problem-solving ability and social networks and taking steps to ensure client safety, if necessary. These practical strategies are tentatively supported by the literature. A lack of social integration has long been considered a key factor in suicidal behaviour (for example, Durkheim, 1897/1952) and building social support networks has been identified as a key aspect of recovery by Lapsley, Nikora and Black (2002). Low self-esteem was discussed throughout Chapter Two as a risk factor occurring from a variety of sources; Overholser, Adams, Lehnert and Brinkman (1995) emphasised the importance of addressing self-esteem deficits, while coping skills and problem-solving strategies have been discussed by Edwards and Holden (2001), McLeavey, Daly, Ludgate, and Murray (1994), Pollock and Williams (2001) and others.

Despite the support for the practical strategies discussed in the preceding paragraph, the literature strongly suggested that clinical interventions require further research and evaluation (Burns & Patton, 2000; Miller & Glinski, 2000; van der Sande et al., 1997). As a group, informants were polarised over the efficacy of clinical interventions and therapy in the current study. Clinicians and others working in the mental health system stressed the importance of clinical intervention. At the same time, other informants were strongly critical of the approaches used by clinicians, particularly in regards to an impersonal stance, punitive attitudes, lack of continuity of care and inappropriate medicating. Counsellors spoke of the importance of dealing with underlying issues, particularly sexual abuse. These informants stressed

the importance of building trusting, positive relationships with clients and their families, which facilitates a commitment to counselling and increases efficacy.

As discussed by Spirito, Boergers and Donaldson (2000), early termination of therapy is common, and several informants discussed this issue. Some informants felt that the quality of the relationship between the counsellor/therapist and client was vital in this regard, and this view is supported by Crockwell and Burford's research (1995). A few informants also mentioned the importance of culturally appropriate services, and this is supported by the work of Durie (1984), for example. However, others placed more importance on external influences such as family support, finances and access to transport, and some viewed non-compliance as a corollary of psychiatric disorder: "People with borderline personality disorder tend to see a number of services, and not stick with them." Overall, informants attributed early termination of counselling or therapy to the client or external influences rather than to any failing of the service or provider.

Views on the role of family and friends in cessation and recovery were somewhat mixed and discussion fairly limited. Some felt that friends and family often made the situation worse through negative reactions, others felt that an out-pouring of love and concern could be exactly what was needed to boost low self-esteem, while some felt that expressions of nurturing and concern could reinforce the suicidal behaviour. The latter concern aligns with the literature, for example, Favazza (1996). On the whole, informants felt that these people could potentially play an important part, but often they were unprepared and poorly-equipped to offer anything but the most rudimentary support. There is surprisingly little discussion of the role of family and friends in the cessation and prevention of suicidal behaviour in the literature, although Lapsley, Nikora and Black (2002) noted that a lack of understanding and rejecting behaviour is a common hindrance to recovery from perceived mental illness.

In summary, there were a number of conflicting views of intervention discussed, with no clear picture of a cohesive strategy apparent, although some individual strategies are well-supported by the literature. This lack of a clear, effective direction is in itself reflected by the literature, which strongly suggested that the area of cessation and recovery from suicidal behaviour is an area in need of further research.

Prevention

Informants identified few prevention strategies. Those that were suggested fell into the categories of community and teacher education about mental health, communication skills and increased accessibility to support services. While the literature on prevention is rather limited, as discussed in Chapter Two, it does appear to support many of the prevention measures suggested by informants in the current study (Ministry of Youth Affairs, Ministry of Health, & Te Puni Kokiri, 1998). A cautionary note is important here though: several of the measures suggested centred on school-based education programmes. While programmes focussing on life skills, mental health promotion and positive communication generally seem worthwhile, those focusing on increasing suicide awareness have received worrying evaluations. As Gould & Kramer (2001) discussed, there is no evidence to suggest that school-based awareness-raising programmes can reduce suicide, and some evidence to the contrary, that discussion of suicidal behaviour can result in imitation.

In conclusion to the Component One findings, there was a large amount of agreement on risk factors, interventions and prevention, overall. However, there was a clear divergence of opinion between two sub-groups that could be broadly categorised as clinicians and mental health service workers, and community-based workers. All agreed that most young women who engage in suicidal behaviour are diagnosable with a mental disorder, most commonly depression, and that a number of social factors also contributed to their suicidality; this perspective is found in the literature on suicidal behaviour. However, the two groups differed over the importance of these factors. Family dysfunction and sexual abuse were considered to be the most common underlying factors, with some informants also identifying youth culture, ethnicity and substance abuse. All of these factors have been researched, and the importance given to them by the informants seems to roughly match that in the literature, with the possible exception of ethnicity. Perspectives on ethnicity varied widely in the current study, but overall more importance appears to have been placed on it than has been seen in the local literature until very recently.

The divergence of opinion about the importance of psychopathology was continued into the perspectives on intervention and prevention. There were two general strategies presented: determining an appropriate diagnosis and medicating

appropriately, and addressing underlying social factors and deficits. All informants agreed that these strategies are often most effective when applied concurrently, but many felt that one strategy was far more important than the other. Additionally, no clear picture of what specific interventions were effective emerged. This could be because appropriate interventions vary according to the individual, but the impression received was that informants felt that the model or approach they were trained in was the most appropriate for most informants. This lack of overall clarity about effective, cohesive therapies is reflected in the literature; researchers have acknowledged a lack of evaluation of interventions. Currently, interventions discussed in the literature and used in New Zealand seem to focus on addressing deficits and providing emergency medical and counselling services.

Informants had relatively few comments on prevention. Again, the strategies suggested tended to focus on addressing deficits, along with some health promotion measures. These strategies were broadly in line with those supported by the literature.

Component Two Findings

Risk Factors

The cause of suicidal behaviour is considered to be multi-factorial, including stressful life events, psychiatric disorder, family dysfunction, abuse and/or neglect, exposure to suicidal behaviour and sexual orientation problems (Coggan et al., 1995). These risk factors have been discussed in more detail in Chapter Two. All participants in Component Two of the research identified a combination of factors leading to suicidal behaviour, although for most there were one or two that were particularly salient. The following section summarises and discusses the findings on specific factors as identified by participants in this component of the research. In addition to biological factors and social factors, the links to non-suicidal self-harming behaviours are discussed. Factors involved in cessation and recovery from suicidal behaviour are then explored.

Biological/Pathological Factors

The majority of participants located the primary reasons for their suicidal behaviour with life events or family factors. Although some participants had received a psychiatric diagnosis, most commonly depression or borderline personality disorder, none identified the disorder as a contributing factor in itself; rather, the common perception appeared to be that social or interpersonal factors led to the negative emotions which led to suicidality, and having a diagnosed mental illness was largely irrelevant. The majority of participants had not received a formal diagnosis, although it seems likely that most, if not all, would have fitted the DSM criteria for depression, in some cases alongside anxiety. Diagnosis does not appear to have positively affected the course of suicidal behaviour and in some cases appears to have negatively impacted recovery, as will be discussed below. As discussed in Chapter Two, Caplan (1995), Kirk and Kutchins (1992), Kutchins and Kirk (1997), Lerman (1996), Link and Phelan (2001) and Weiner and Marcus (1994) suggested that many so-called mental illnesses and diagnostic criteria are culture-bound; certainly few of the participants in this research found being diagnosed with a mental illness helpful.

Two participants considered the primary cause of their depression to be due to biochemical processes. For Lucy, depression appears to have been linked to use of the contraceptive pill. Kate considers her depression and anxiety to be genetic and is resigned to long-term anti-depressant usage. These two are the only participants who found identification of a physiological cause of their depression to be helpful. In addition, Dana suffered from post-natal depression, exacerbating the depression she had felt for several years.

Several participants mentioned that 'depression runs in the family'. These participants also identified life events as contributing significantly to their depression, and felt that genetic factors were secondary.

Abuse

Apart from Lucy, Dana and Kate, all participants identified abuse or neglect as the major 'cause' of suicidal behaviour. The abuse identified by participants included sexual, physical and emotional abuse and neglect. The most commonly discussed form was sexual abuse.

Sexual Abuse.

Survivors learn early that they have no voice

They see no evil

They hear no evil

They speak no evil

They just feel evil

(Hernandez, 1986, p. 11, cited by Fondacaro & Butler, 1995)

Sexual abuse was by far the most important factor identified, both quantitatively and qualitatively, when considering the participants as a group. The majority of participants (15, possibly 16, of 24) had been sexually abused during childhood. All of these women considered it to be the most important factor in their subsequent suicidal behaviour, although some noted that related factors exacerbated the abuse. In addition, two of the women who had not been sexually abused discussed their first experience of sexual intercourse as a precipitator of suicidal behaviour, due to the circumstances under which the experience occurred. In both cases, sexual experience was in conflict with their strongly-held religious beliefs and alcohol had been consumed, suggesting that the experience was not fully consensual.

The literature on childhood sexual abuse discussed depression and suicidal behaviour as possible outcomes (for example, Boudewyn & Liem, 1995; Rodriguez-Srednicki, 2001; Romans, Martin, & Mullen, 1997; Wagner, 1994). While the literature on youth suicidal behaviour also lists sexual abuse as a risk factor (Ministry of Youth Affairs et al., 1998; Romans, 1995), it is not given the importance that this study suggests it deserves. This may be because much of the literature is not gender-differentiated and females have been thought to be more likely to be victims of sexual abuse than males.

In addition to sexual abuse itself, many of the participants who were survivors of abuse spoke of exacerbating factors, most commonly around disclosure of the abuse. As Muir (1993) and Myer (1985) discussed, it is not uncommon for disclosure of abuse to be met with unsatisfactory responses, if not outright denial, and this was the case for several participants in this study. This resulted in rejection of the abuse survivor, and, in some cases, continuation of the abuse. Other participants were believed and supported when they initially disclosed sexual abuse, but found the

process of taking criminal proceedings against the abuser traumatic. In other cases disclosure of abuse resulted in disclosures by other family members, with major family upheaval ensuing. Some participants suggested that the results of disclosure were more traumatising than the abuse itself. This finding suggests that a history of sexual abuse gave rise to another risk factor: unsupportive reactions to disclosure.

Although the sexual abuse literature does suggest that survivors are at increased risk of suicidal behaviour (for example, McCauley et al., 1997; Rodriguez-Srednicki, 2001), it would seem that most survivors of sexual abuse do not resort to suicidal behaviour. However, this study strongly suggests that females who engage in suicidal behaviour are likely to have been sexually abused. This finding concurs with that of Romans, Martin, Anderson, Herbison, and Mullen (1995). It should be noted, however, that there is a danger in assuming that all suicidal females have been sexually abused. Several participants spoke of being pressured to disclose abuse before they were ready, and the negative impact this had on them. While many participants acknowledged the importance of dealing with experiences of sexual abuse, the necessity of allowing the abuse survivor to control the disclosure process was stressed. All the participants who had been sexually abused spoke about this passionately. It is unclear why some girls who have been sexually abused go on to engage in suicidal behaviour, and others do not. However, the presence of protective factors such as a supportive environment generally and strong self-esteem, as discussed in Chapter Two, and appropriate response to disclosure, may well explain this divergence.

It appears from this study that disclosure of sexual abuse, and the ways which disclosures are dealt with, play a vital role in determining the course of related depression and suicidality. While responses to disclosure are discussed in the literature (Candib, 1999; Holguin & Hansen, 2002), a possible relationship between the handling of disclosures and suicidal behaviour does not appear to have been examined.

While agreeing with Romans and colleagues' (1997) finding that sexual abuse alone is neither necessary nor sufficient in itself to lead to suicidal behaviour, the finding that the majority of participants felt that if they had not been sexually abused or if their

disclosures of sexual abuse had been handled appropriately they would not have become suicidal is particularly noteworthy.

Physical and Emotional Abuse and Neglect.

Nine participants discussed physical abuse within the family as a factor in their suicidal behaviour. However, although physical abuse is associated with a marked increase in suicide attempts (Ministry of Health, 1998), participants in this study did not appear to think that physical abuse was as important a factor as other forms of abuse, including emotional abuse and neglect, as well as sexual abuse. Although the importance of emotional abuse was initially unexpected, it does agree with Thompson, Kaslow, Bradshaw Lane and Kingere's (2000) finding that emotional abuse was more strongly associated with women's suicide attempts than other forms of childhood maltreatment.

Most of those who were sexually abused also discussed emotional abuse, sometimes occurring to facilitate sexual abuse. Some participants spoke of the long-term consequences of verbal abuse, arguing that the impact of being told that one is bad, unwanted or a failure is more damaging than a physical assault. Participants also spoke of the negative impact of feeling emotionally neglected; these reported fit with the work of Lipschitz and colleagues (1999) and Gibb and colleagues (2001) who suggested emotional abuse and neglect results in low self-esteem, hopelessness and suicidal behaviour.

Other Family Factors

Eight of the 24 participants reported parental divorce. In addition, there appears to have been a high degree of conflict within the other participants' families. Nine participants' families had histories of suicidal behaviour; this is discussed in more detail below. Four participants had one or both parents die prior to the participant's suicidal behaviour and all identified this as a contributing factor; in two cases the cause of death was suicide. Several participants mentioned severe depression within the immediate family, usually the participant's mother. An adverse family environment is well-established, both locally and internationally, as a risk factor for suicidal behaviour, so these findings are unsurprising (for example, Beautrais, Joyce, & Mulder, 1996; Blau, 1996; Ministry of Health, 1996).

Social Isolation

Social isolation was a common theme in participants' narratives. Usually this isolation was attributed to personality traits, such as shyness or being a 'nerd'. In three cases participants were ostracised due to their religious beliefs, and in two cases (Richelle and Wendy) social isolation was a deliberate controlling tactic on the part of abusers. For several participants, social isolation occurred abruptly, when an intimate relationship broke down. For most of these participants this relationship had been the major source of social support. In all cases this isolation was discussed as contributing to a lack of self-esteem and subsequent suicidality. In some cases isolation increased or occurred as a result of depression. A lack of social support is strongly associated with suicidal behaviour, according to Lapsley, Nikora, and Black (2002).

Some participants noted that their depression did not appear to be noticed *because they* were socially withdrawn. Kate observed that she was very quiet and this was considered by her parents and teachers to be a good thing; she felt it was due to her poor self-esteem and depression. Louise mentioned that her mother did not realise how depressed she was because she isolated herself from her parents; when she spent time alone in her room her parents assumed she was studying. The interplay between social withdrawal or isolation and depression can be reciprocal and therefore can become self-perpetuating.

Sexual Orientation

Of the 24 participants in Component Two of this study, three identified as lesbians; this does not appear to be out of proportion to the general population. While two of these three women did consider that coming out as a lesbian was a contributor to their subsequent suicidal behaviour, they stressed that it was one of several factors. Given the sample size, clear conclusions can not be drawn from these findings, although they do suggest that sexual orientation is not a key factor in New Zealand's high rates of female suicidal behaviour. As discussed in Chapter Two, research into the association between gay, lesbian and bisexual orientation and suicidal behaviour has been inconclusive. However, current opinion seems to be that gay, lesbian and

bisexual youth are at increased risk of suicidal behaviour, but the risk appears to be greater for males than females (Garofalo, Wolf, Wissow, Woods, & Goodman, 1999).

Loss

Loss of a parent through death was a significant contributing factor for four participants. In one case both parents died within a month, the second being a suicide. One participant's mother killed herself and the participant's sister. Additionally, the loss of the ability to play sport was mentioned by three participants as contributing to suicidality; for these young women excelling at sport had been a key source of self-esteem. Although in all these cases there were other factors involved, it appears that loss led to feelings of instability and uncertainty.

School

Some of the research available to me (for example, Adams Thompson, Eggert, Randell, & Pike, 2001) suggested that school failure is an important correlate for youth suicide; several participants discussed school as a risk factor or trigger for suicidal behaviour, although it was generally considered relatively minor and set against a background of more serious events and circumstances. For most of these women, such as Louise and Wendy, grades slipped as a result of having to take subjects that they were not interested in due to 'streaming' processes³³. Interestingly, all the participants who discussed this had previously been very successful academically and considered themselves to be capable students; the issue was of 'falling from grace'; excelling at school had been an important source of self-esteem, as opposed to having a long history of schooling difficulties. Most have since gone on to pursue university degrees. There is some suggestion in the literature that gifted students may be at higher risk of suicidality than their peers (Gust-Brey, 1999).

Several participants mentioned school as a location in which they felt unhappy, usually due to social isolation rather than to academic difficulties per se.

³³ 'Streaming' refers to the process whereby students are assigned to classes according to their academic ability; students of outstanding ability are assigned to the 'top-stream' and are usually expected to take language or science courses, while those assigned to the 'bottom-stream' are expected to take vocational courses.

Suicidality in Family or Social Networks

Hazell and Lewin (1993) estimate that up to 20% of adolescents know of a friend's suicide attempt. It is known that suicidal behaviour in an individual's family or social circle increases the risk of suicidality in the individual (Brent, Bridge, Johnson, & Connolly, 1996); in the current study nine of the 24 participants discussed suicidal behaviour in a family member and another three discussed completed or attempted suicide in their social networks. Four participants were aware of suicidal behaviour in more than one close family member or friend. This equated to 11 participants who were aware of suicidal behaviour in someone close to them.

The evidence for 'copy-cat' suicides has been researched, although, as discussed in Chapter Two, the processes are not entirely clear (Brent et al., 1993; Brent, Bridge, Johnson & Connolly, 1996; Hazel & Lewin, 1993). The results of this study suggested that the suicidal behaviour of another increases the likelihood of suicide being seen as a reasonable choice. Although one might think that seeing the impact of a suicide on the family and friends might be a deterrent, this clearly is not always the case. Interestingly though, Collette mentioned a relative's attempted suicide as suggesting the behaviour as an option, while a subsequent completed suicide by another family member made her aware of the impact on loved ones and discouraged further attempts.

Several participants mentioned joining support groups to deal with depression or self-harming behaviour and subsequently learning new means of self-harm from group members, or forming friendships in which they encouraged each others' self-harm. This is discussed in more detail in the section on interventions.

Loss of Control/Power

Almost all of the participants in the current study spoke of feeling out of control or powerless; this was particularly common among those who had been physically and/or sexually abused. This perception called to mind Alderman's (1997) discussion of control and self-mutilation and Lawrence's (1979) discussion of a control paradox in anorexics, wherein anorexics experience themselves as powerless

and out of control, and seek to overcome this through controlling their body and through a form of moral control: self-denial. However, the concept seems to be largely unexplored in the literature in relation to suicidal behaviour, other than in reference to concepts of helplessness and hopelessness. As such, this appears to be a particularly important finding.

Orbach and colleagues' concept of 'bodily control' seems somewhat narrower than the way in which participants in the current study spoke of control of their bodies; for example, measures in Orbach and colleagues (2001) study included "I can't control my appetite", "every change in my body frightens me" and "sometimes I try to test how much physical effort my body can take" whereas participants such as Sue spoke of regaining control of their bodies once a sexual abuser had been imprisoned; Hayley desired to take control of her body through starving herself. However, the results of Orbach and colleagues study do seem to have relevance to the current study, particularly the notion of bodily control. Orbach and colleagues suggested that negative life events can result in alteration of perceptions, feelings and experiences of the body resulting in body hate, bodily detachment, sense of lack of control and loss of bodily boundaries and believed that these perceptions and experiences may translate into self-destructive behaviour. As Orbach and colleagues discussed, an examination of the role of trauma and negative effects would be useful; it appears that in the current study the ideas of bodily control and powerlessness were most salient to those who had been physically and/or sexually abused.

The concepts of body hate, bodily detachment, lack of control and loss of bodily boundaries are reflected in the observations of the participants in the current study. Whereas participants in Orbach's study spoke of control of their bodies, participants in the current study also spoke of a lack of control of their emotions, resulting in feelings of hopelessness and helplessness and feeling that their distress was out of control. Participants also discussed a lack of control over relationships, particularly those where there was a perceived imbalance of power, such as with parents or counsellors and fear of continuing abuse. The participants spoke of taking control through various self-harming behaviours, including suicidal behaviour, as well as gaining convictions against an abuser, for example. Participants described these actions as claiming a sense of ownership of their body, and their life/death. Jen's

comment that “the only thing I had control over was whether I lived or died” expressed a common sentiment.

In some cases the feeling of loss of control was directly based on life circumstances. Richelle and Jen’s experiences provided exemplars of this. Richelle was kept socially isolated, having no contact with people outside the family without a parent present. Her life was dominated by the erratic and physically abusive behaviour of her mother, and the sexual abuse perpetrated by her father. Jen was sent to a boarding school, against her wishes, following the deaths of her parents. Her life was strictly regimented by the routines of the school. While all the students’ lives were structured in this way, Jen had the additional burden of having no holiday breaks from this routine, except to stay with extended family where she was sexually abused. Disclosure of the abuse had been met with denial. Richelle’s and Jen’s sense of lack of control was well-founded, and their belief that the only thing they had control over was their deaths seems understandable under the circumstances. As Wiener and Marcus (1994) pointed out, feelings of helplessness and powerlessness do not occur in social vacua. The participants who particularly stressed the importance of control were largely those who had been sexually abused. For these women the control they had lost was over intimate access to their bodies. Through focussing on their bodies through disciplining or harming behaviours they sought to regain control. Figure 3, below, summarises reasons for feeling out of control and lists a number of methods used for gaining a sense of control.

Figure 3: Perceived loss of control: underlying issues, rectifying behaviours and results.

Sense of being out of control of:

Environment	Relationships with	Emotions
<ul style="list-style-type: none">• work• school• home	<ul style="list-style-type: none">• parent• abuser³⁴• significant other• counsellor	<ul style="list-style-type: none">• hopelessness• helplessness• fear of future• fear of escalating emotions• fear of abuse

Dealt with through:

<ul style="list-style-type: none">• school achievement• gaining a conviction• risk-taking	<ul style="list-style-type: none">• starving• substance use• other externalising behaviour³⁵	<ul style="list-style-type: none">• mutilating• suicide attempt
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Resulting in:

<p>Control:</p> <p>Of the body; of life/death; of emotional pain; delineating a boundary which no-one else can cross</p>

Loss of Self-esteem

A lack of self-esteem, often manifesting in extreme forms such as self-loathing, was frequently identified by participants in the current study, and seemed to be very important. This fits with research into the importance of self-esteem (for example, Overholser, Adams, Lehnert & Brinkman, 1995).

³⁴ It should be noted that, in all but two cases in the current research, participants were no longer being abused. In one case, the participant made her first suicide attempt at age 8; the sexual abuse continued for some years. In the other case, the participant had left home, which was the original source of precipitating factors, but was living with an abusive partner.

³⁵ These behaviours may include acting unaffected, blasé, getting tattoos or piercings.

For many this lack of self-esteem resulted from sexual abuse, although emotional abuse was also frequently mentioned as a contributor. Usually this emotional abuse occurred within the family, often, although not exclusively, perpetrated by the participants' fathers. Few participants mentioned bullying or teasing by their peers as a contributing factor.

As discussed above, several participants mentioned poor grades affecting their self-esteem, but this does not appear to have had as much impact as other sources of poor self-esteem.

Music Choices

The impact of music on suicidal youth has received continuing news media attention, particularly 'heavy metal' music. Although three participants mentioned listening to 'depressing' music, it was not considered by any to be an important factor; rather, participants listened to this music when already depressed. As examined in the Component One discussion, listening to music does not appear to significantly increase risk of suicidal behaviour: people who listen to certain types of music such as heavy metal are at increased risk of suicidal behaviour for other reasons. These opinions are supported by the research of Scheel and Westfield (1999).

Non-suicidal self-harming behaviours

As discussed in Chapters One and Two, self-harming behaviours are usually described as existing on a continuum, beginning with low-level risk-taking or lack of self-care, possibly progressing through eating and/or exercising issues and substance abuse, then self-mutilation to actively suicidal behaviour. Although some overlaps between these behaviours and populations are discussed in the literature, they are often treated as distinct behaviours. Most participants in the current study engaged in at least one of these behaviours. This section explores the various behaviours discussed and concludes with observations on the relationships between the behaviours.

Substance Abuse

Nearly half the participants in the current study discussed using drugs or alcohol in relation to their suicidal behaviour, but few considered substance use to have been a particular problem in itself. Rather, use of substances appears for some to have been a way of dealing with the underlying issues that also lead to suicidal behaviour, while for others it seems to have been relatively normal behaviour in their social circle. This framing of substance use as a co-occurrence rather than a cause of suicidal behaviour is supported by the research of Beautrais (1997).

Eating Disorders

Several participants mentioned having an eating disorder. However, for most this was a relatively short-lived stage that was overshadowed by suicidal or self-mutilating behaviour.

Self-mutilation

When this research was being planned, it was not expected that self-mutilation would be discussed in any depth. However, seventeen of the 24 participants in the current study had engaged in some form of self-mutilation, most commonly cutting. All of these participants volunteered information on self-mutilation without the topic being raised by the researcher, suggesting that they saw connections between the two types of behaviour. The high number of participants who had engaged in self-mutilation either before or after a suicide attempt also suggests a link between the two behaviours, especially given that most of the participants talked about self-mutilation as a way of dealing with suicidal feelings. However, while both self-mutilation and suicidal behaviour are forms of self-harm, a review of the literature (as discussed in Chapter Two) suggested that they are generally considered two separate phenomena (Alderman, 1997; Walsh & Rosen, 1988; White & Stillion, 1988).

There appears to be a definite relationship between self-mutilation and suicidal behaviour for the majority of participants in the current study. From the descriptions given by those participants who self-mutilated, self-mutilation and suicidal behaviour are quite distinct. They served different purposes, in that the goal of self-mutilation was primarily to release tension in the short-term, while the goal of

suicidal behaviour was to remove oneself from an aversive situation permanently, either through death or by obtaining assistance through calling attention to distress. Self-mutilation also fulfilled various other goals, such as changing the focus of pain from emotional to physical, releasing anger, making a statement of strength, punishing oneself and reclaiming control over the body. In addition, the methods used for self-mutilation were usually different from those used for suicidal behaviour; only two participants cut themselves both as a form of self-mutilation and as suicidal behaviour. In short, the goal of self-mutilation is to feel better, as opposed to the usual goal of suicidal behaviour, to not feel at all; this observation has also been made by Alderman (1997). The participants were quite clear about which specific events were intended as self-mutilation and which were suicidal. Yet participants also spoke about cutting or burning themselves as a way of coping with suicidal feelings, and made links between the behaviours. The motivation of taking control through self-harm reflects Favazza's (1996) and Levenkron's (1998) theories that physical pain may provide relief from emotional pain and tension.

It appears for most participants that a corollary of using self-mutilation as a way of dealing with emotional distress and providing a sense of relief was averting suicidal feelings; usually the act of cutting or burning was repeated several times for this purpose. Eventually, however, the relief provided in this way was found to be inadequate, and actively suicidal behaviour was engaged in. A few participants stopped their self-harming behaviour after one suicide attempt, but the majority went on to either continue mutilating themselves, or to make further suicide attempts, or both. Most self-mutilators continued to mutilate for some time after their last suicide attempt.

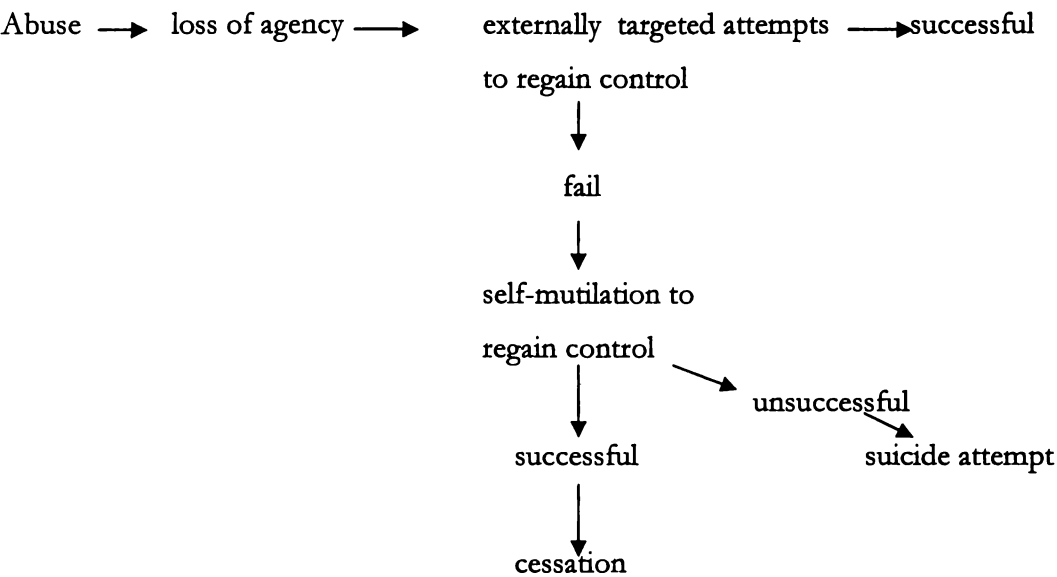
All but two of the participants who self-mutilated had been sexually abused, and most of those who had been sexually abused self-mutilated. All the participants who self-mutilated had suffered emotional abuse.

Usually self-mutilation was a secret or private activity, although three participants described having friends who also mutilated, and sometimes they would engage in the behaviour together; in two cases the behaviour became competitive. While all participants recognised that the behaviour would generally not be considered 'normal', several felt that it was an adaptive coping mechanism, commenting, for

example, that it was less damaging than heavy substance abuse. Relief of tension as a reason for self-mutilation is well-established; Gardner and Gardner (1975) suggested that each time self-cutting is carried out positive reinforcement occurs as a result of this pleasurable release, thereby strengthening the tendency to repeat the behaviour. This finding fits well with the descriptions of the behaviour given by the participants of the current study; participants discussed the difficulty in stopping and the need to find other coping behaviours. For many participants it was not possible at the time to find another coping strategy that could favourably compare with the immediate relief provided by cutting or burning oneself.

In general, the findings of this study in relation to self-mutilation are in accordance with the findings of other studies as discussed in Chapter Two. The behaviour was usually carried out in secret, primarily as a way of dealing with negative emotions. The behaviour was not suicidal, and in fact was clearly counter-suicidal. Although most of the participants had not received diagnoses of mental disorders, most of those self-mutilators who had been diagnosed were labelled as having borderline personality disorder. Walsh and Rosen (1988) suggested that a history of sexual abuse is the most significant factor in discriminating between self-mutilators who had also been suicidal and those who had not. Self-mutilators who had not been suicidal were not included in the current study, but all but two of the self-mutilators had been sexually abused, suggesting that this link is worthy of further investigation. Feelings of powerlessness and lack of control of the body or of emotions were also salient to most of these women. The relationship between abuse (whether emotional, physical or sexual), loss of control, and self-harming behaviours is illustrated in Figure 4, below:

Figure 4: Pathway between abuse and self-harming behaviours, motivated by perceived loss of control.



It appears that in most cases the sense of control achieved is short-lived, resulting in further self-harming behaviour.

There are two key points of difference between findings discussed in the literature, and the results of the current study. First is the number of participants in this study, which aimed to explore suicidal behaviour with no particular interest in self-mutilation, who had also self-mutilated. Second is the qualitative link made by participants between two sets of behaviours usually viewed in the literature as distinct (although occasionally overlapping). Together, these findings suggested that for young women self-mutilation and suicidal behaviour are more closely related than has previously been acknowledged. This may have implications for prevention and intervention strategies, particularly as many of the participants had self-mutilated, sometimes receiving medical attention, before engaging in suicidal behaviour.

Internalising and Externalising Behaviour

Although the current research suggests that risk-taking, attention-grabbing behaviour is far more common than internalising behaviour, it may well be that the behaviour changes according to the context. For example, many of the women in this study

talked about withdrawing from their family, and having little interaction with them; therefore, the family would not have been aware of risk-taking behaviour. It also seems possible that the type of behaviour varied according to the level of depression; when young women were more acutely suicidal it seems they were more likely to withdraw; if they had the energy to engage in 'acting out' behaviour, they may actually have been feeling better. The notion of a shift from 'acting out' to withdrawing to suicidal behaviour was mentioned by some Component One informants, but it is not something I have seen in previous research, although Langhinrichsen-Rohling and colleagues (1998) suggested that disruptive and internalising behaviours are interrelated, and both internalising and externalising problem behaviours have successfully predicted suicidal behaviour in adolescents (Lewinsohn et al., 1993).

There are a number of behaviours discussed by participants that were potential warning signs. These include pre-occupation with weight, lack of self-care, for example, appearing unkempt, and choice of music. Of course, young people who are not suicidal exhibit many of these 'signs'.

In summary, it seems that initially one set of behaviours was sufficient to deal with negative emotions (including powerlessness, helplessness, fear, depression and anxiety, as well as suicidal thoughts), but, over time, individuals moved another step along the 'continuum'. While for some this progression halted with a suicide attempt, the majority cycled back through. Although the research literature discussed self-harming behaviours as existing on a continuum, it appears that a cyclical model of behaviour is more appropriate. The timing of this cycling varied considerably among individuals; some engaged in some form of self-harm on a daily basis, while, for others, the behaviour would result in a period of relative 'peace' for weeks. In addition, the timing of the cycling varied for each individual: for most, each time the behaviour was engaged in the result was less effective, so the severity or the frequency of the behaviour would increase, until the decision was made to actively attempt suicide.

Nine of the 24 participants made one suicide attempt, but the average was three, with the highest number of suicide attempts made by a single participant being 13³⁶. The most common method was drug overdose, used at least once by 22 of the 24 participants. This is confirmed by Beautrais (2000) who reported that for the 1995/1996 fiscal year (the most recent statistics available) self-poisoning with solid or liquid substances accounted for 87.6% of all hospitalisations for suicide attempts in people aged 15 to 24 years³⁷. The most commonly used class of substance for overdosing was prescribed anti-depressant or anxiety medication, followed by non-prescription painkillers, often in combination with alcohol. Paracetamol was the single most common medication used.

The second most common method, used by six participants at least once, was cutting, usually of the wrists. However, five participants used more than one method. Only 13 of the 24 participants had been hospitalised, totalling 23 hospitalisations. Six participants had been treated as out-patients, and the remaining five participants did not receive medical attention immediately following suicidal behaviour, although some did seek help from a general practitioner at a later point, usually seeking anti-depressant medication or a referral to counselling.

As mentioned in Chapter Two, statistics (Ministry of Health, 1996) suggested that suicidality is unusual in children under the age of 13. However, two participants in this research made suicide attempts at age eight and one at age 12. None of these suicide attempts resulted in medical attention and so would not have been recorded. In addition, Rhonda said she had wished to “die, go to sleep and never wake up” from the age of six and Evelyn had thoughts of death and killing herself while at primary school.

³⁶ See Chapter Five for a more detailed discussion of the suicidal behaviour engaged in by the participants.

³⁷ In contrast, hanging and strangulation were the most common methods of completed suicide, accounting for 36.6% of female deaths. Poisoning by solid or liquid substances accounted for 25.9%, and poisoning by gas accounted for 27.7 of female deaths.

Intention to die

Participants in this component of the study self-identified as having engaged in suicidal behaviour; indeed, the area of interest of the study was explicit in all recruitment materials, and participants volunteered because they had been suicidal and wished to discuss their behaviour. Most participants spoke explicitly of wanting to die, and expected to die as a result of their suicidal behaviour; indeed, several mentioned their anger or frustration at not dying. Several participants spoke of initially engaging in behaviour that was, in fact, designed to draw attention to their distress. In all but one of these cases, the participants went on to make 'serious' suicide attempts. Those who did not speak explicitly of death nevertheless classified themselves as wanting to commit suicide.

Stephens' (1995) review of the literature on the intentions of female suicidal behaviour concludes that researchers and theorists are sceptical about the nature of these acts, to the point of challenging the notion that it is in fact suicidal phenomena. The corollary is that the behaviour is usually manipulative; 'tests of love' aimed at changing stressful situations or relationships. Stephens' own research did not support this perspective; although acknowledging the difficulty in determining intent, she found that 70% of the adult American women in her study appeared to intend to die. Another example of the scepticism with which female suicidal behaviour is viewed is that of Blau (1996). He is of the view that it is a myth that suicidal youth are intent on dying, arguing that most suicidal teens are ambivalent and, instead, view death as a way to avoid suffering. However, the premises of the latter part of Blau's argument do not appear to be mutually exclusive. The majority of women in this study did appear to be quite clear in their intentions to die but they also saw death as a way to avoid suffering. It appears that suicide was seen as a last resort and the participants in this study saw no other way to deal with their situation. However, several participants became afraid of death after taking overdoses, and then contacted emergency services. All of these women wanted to die at the time of taking the overdose, and all engaged in suicidal behaviour repeatedly. Most of this group gave up their suicidal behaviour, in part, because they had repeatedly been unsuccessful, but they still continued to experience periods of suicidal ideation for some time. Several participants expressed annoyance at merely being considered 'attention-seekers', whether self-mutilating or engaging in serious suicide attempts: they viewed their behaviour as serious and desperate. The condemnation of self-

mutilators as attention-seekers has been discussed, and, in turn, condemned, by Stanley, Geameroff, Michalson and Mann (2001).

It may also be that some of those who are assumed to be ‘merely attention-seekers’ who do not actually want to die are in fact self-mutilators, whose behaviour is neither intended to be fatal, nor to give the appearance of suicidal behaviour. Nonetheless, it is behaviour to be taken seriously.

Although statistics (Ministry of Health, 1996) suggest that hospitalisation for deliberate self-injury, and therefore suicidal behaviour, in pre-teen children is very uncommon, several participants in this study mentioned having thought about suicide, and in two cases making attempts, while aged under 13. Mishara (1999) reported that, by the age of eight, American school children have an understanding of death and suicide, and younger children usually have an understanding of the concept ‘killing oneself’ although their understanding of death may not be fully developed. American children discussed suicide with other children, having often learnt about it from television, although they rarely discussed suicide with adults. It may be that, due to Ministry of Health guidelines on restriction of media discussion of suicide, New Zealand children are not as exposed to suicide through the media. However, they may be more likely to be exposed to it through real life situations, given New Zealand’s high rate of suicidal behaviour; nearly half the participants in the current study discussed suicidal behaviour in family members, friends and neighbours prior to their own.

Summary

The participants in this component of the research identified a range of factors that lead to their suicidal behaviour. All participants mentioned some level of family dysfunction, although two women believed this was secondary to biochemical processes. Many participants discussed sexual abuse as a key factor, often exacerbated by problems with disclosure. A number of other factors were identified; these included social isolation, emotional abuse and a lack of self-esteem. Feelings of powerlessness were frequently discussed.

In addition to risk factors, many participants mentioned related behaviours, particularly self-mutilation. Although the differing aims of self-mutilation and

suicidal behaviour were identified, participants made clear links between the behaviours. This relationship between the two behaviours is in contrast to the majority of the research that, although acknowledging some overlap, views the two types of behaviour as quite distinct.

The literature discussed elsewhere suggests that female 'suicidal behaviour' is often, in fact, a manipulative device. In contrast, the participants in this study described their suicidal behaviour as serious attempts to die. While some participants changed their minds very shortly after engaging in suicidal behaviour, at the moment of taking an overdose or cutting their wrists they were serious in their intent. Also in contrast to statistics, this research suggests that suicidality does occur in children under the age of 13.

Cessation and Recovery

The following section discusses cessation of and recovery from suicidal behaviour. It explores the aspects of recovery that were most salient for participants in the current study, with reference to the research literature. As discussed in Chapter Four, it is important here to make a distinction between cessation and recovery. In the former, the individual experiences a decrease in suicidal behaviour; in the latter they are developing coping strategies, problem-solving skills and therefore are less likely to feel suicidal. Most participants continued to feel suicidal for some time after their last suicide attempt, in some cases for years, but used other ways of coping. Individuals may, for example, cease their suicidal behaviour because they have increased use of substances in an attempt to self-medicate or continue to self-mutilate. While these individuals have achieved cessation, it could not be said that they have truly recovered. All the participants in this research considered that they had recovered; this was a criteria for taking part in the research. However, four said that they still occasionally had suicidal feelings but were confident of their ability to cope with these.

A variety of reasons were given for not continuing suicidal behaviour, as discussed in the previous chapter. In summary, these include family reactions, which participants experienced in a variety of ways such as feeling loved and valued, to feeling guilty for making parents angry or worried, or an absence of reaction. Concern regarding the

consequences of not succeeding, such as being hospitalised or stigmatised were commonly cited. Participants also gave reasons for continuing suicidal behaviour. The most common was simply continuing to want to die. However reinforcement of the behaviour through attention was also mentioned by several participants, who voiced a desire to be rescued.

Interventions/Treatment/Counselling

Participants spoke of several clinical interventions on the part of mental health services such as CAT Teams, hospital-based clinicians and general practitioners.

Hospitalisation generally kept participants free from harming themselves while they were patients, but it appeared to be of little other benefit. As discussed in detail in the previous chapter, participants mentioned finding treatments to be aversive and learnt new ways of harming themselves from other patients. At best, hospitalisation was an opportunity for respite. While temporary prevention of further self-harm is a benefit in itself, treatments or therapies to facilitate true recovery appear to have not been available in hospitals, or were not found helpful by the participants in this research.

Nearly one third of participants had contact with a CAT Team on at least one occasion. Although none of the participants spoke about their experiences in detail, it appears that the service was generally efficient, although three participants who called the service on several occasions report that the team became less responsive or less helpful. It appears that this was related to the number of times the individual had contacted the team; initially the response was swift and helpful, but as the number of call-outs increased, the service deteriorated, until, in Richelle's case, the Team refused to attend at all.

Similarly, reports on the helpfulness of counselling and therapy with psychologists, psychiatrists and others in the mental health service were mixed. More than half the participants had had contact with a mental health professional; all reported that at least one of the professionals they saw was unhelpful, and eight considered the contact to be detrimental to their well-being. Indeed, it would be fair to say that many reports on the mental health services available to them were scathing. Two

participants suffered from confidentiality breaches. It is worth noting, however, that most participants persevered in their efforts to seek professional help, and all of those eventually did find someone they could work with effectively. In most cases this involved counsellors from community organisations rather than within the mental health service per se. Five participants did not have professional help around their suicidal behaviour, but all except two have had counselling at some point, perhaps years later.

Participants discussed several specific therapy techniques, including Cognitive Behavioural Therapy, Dialectical Behaviour Therapy and Narrative Therapy. While a comprehensive evaluation of these individual therapies is beyond the scope of this thesis, participants stressed the importance of learning coping strategies and problem-solving skills that would be useful in the long-term, as well as coming to terms with issues such as abuse and understanding the background to their suicidal behaviour. The overall impression received from participants is that few of the practitioners they saw combined counselling with the practical skill development mentioned.

Reactions to medication were also ambivalent, although not as negative overall as responses to psychological therapy. Some participants discussed the negative affects of medication; many participants felt that some medications had little or no effect. However, several did find medication to be of great benefit. Almost all the participants strongly felt that medication should be supplemented by counselling or therapy to address the underlying causes of depression or anxiety. This finding calls into question the reliance on medication of many of the general practitioners who participants consulted, as well as the medical paradigm associated with much of the research literature which focuses on psychopathology, as discussed in Chapter Two.

Slightly over half the participants (13) had counselling through a community organisation. Although the overall impression is that participants' experiences were more positive than with the mental health service, responses were mixed. The majority found their first experiences of counselling to be ineffective, and in some cases detrimental, although two participants found their first counsellor to be helpful. Half the participants persevered with their search for assistance and eventually found a counsellor who met their needs. Most participants who persevered eventually

found counselling to be of great benefit to them; the difficulty was in finding someone who matched their needs.

Several participants contacted a school counsellor for assistance. Usually the participants were referred on to a professional service. It was suggested by three participants that follow-up by the school counsellors may have been beneficial as the referrals were not suitable, and the participants were left feeling that no one could help them.

For those for whom counselling/therapy was successful, the key features were:

- an empathic counsellor
- a sense of control or partnership in the counselling process
- feeling listened to
- not feeling blamed/invited to feel guilty for their actions
- not feeling judged
- not feeling like a burden, as compared to trying to talk to family or friends and having to censor what was said for fear of worrying or hurting them
- feeling the counsellor could relate to what they were saying – similar age and/or background and/or experiences
- feeling that the counsellor genuinely cared
- feeling the counsellor could be trusted – this was a particularly important issue for women who felt betrayed by a number of people in their lives including parents and previous counsellors.

In addition, four participants spoke about joining support groups. While one found the experience solely beneficial, the others spoke about the disadvantages of identifying or forming friendships with group members and being influenced by their behaviour. Two participants learnt new ways of harming themselves from group members, while another spoke of a tendency for other group members to 'relapse' if one group member did.

It should be noted that dissatisfaction with interventions may be an anomaly related to the research method. It may be that many potentially suicidal women receive satisfactory and effective interventions and so do not engage in suicidal behaviour

and therefore did not qualify to be involved in this research. However, dissatisfaction with interventions is unsurprising when viewed in the light of the research into the efficacy of interventions discussed in Chapter Two. As Burns and Patton (2000) and van der Sande and colleagues (1997) discussed, there is limited knowledge about efficacious methods of therapy or intervention for young suicide attempters. Further, Hatcher (1997) reported that the provision of hospital services which could be of benefit to these women was unplanned and disorganised. Issues of more concern are the general lack of follow-up for young women presenting with suicidal behaviour, and some practices which seem inappropriate, such as nurses instructing individuals on how to cut their wrists properly, trivialisation and minimisation of sexual abuse which participants felt was integral to their becoming suicidal, and pressure to disclose abuse.

The Role of Family and Friends in Recovery

Support from others was a key aspect of recovery for most participants; this support came from several sources. Gaining appropriate support from professionals seems to have been fraught with difficulties for most participants, including aversive medical practices, inappropriate questioning or approaches and minimisation of experiences, as well as difficulties with medication. Friends were generally found to be more supportive than parents, although this was not always the case.

The family of most, but not all, participants knew of their suicidal behaviour. In the majority of cases the family did little to help the participant through this period in her life, although this was not always due to a lack of concern. Several participants spoke of intense distress on the part of parents, but they did not know what they could do to assist. These participants commented on the lack of support available for their families; this was a particular problem for families in which sexual abuse was a concern. For some, the disclosure of abuse resulted in disclosures by other family members, accompanied by guilt about not protecting the participant. For others, participants' disclosure of abuse resulted in intense anger and shame on the part of family members.

Many participants spoke about the shame and anger expressed by family members, particularly fathers, about the participants' suicidal behaviour. Several parents told

their daughters to 'snap out of it' or made similar comments, while other families apparently chose to ignore the behaviour.

Generally, the response of friends was better, although mixed overall. Some participants were embarrassed to talk to friends about their suicidal behaviour, while for others social isolation and a lack of friends had been a factor in becoming suicidal. Others found friends to be very helpful and supportive; participants spoke about being able to talk without being judged, and feeling cared for and valued. These positive comments reflect Muir's (2001) findings regarding the support of friends around disclosure of sexual abuse. Some friends asked participants to promise not to attempt suicide again, which the participants took as a sign that they were genuinely cared for. On the other hand, two participants engaged in suicidal and self-harming behaviour with friends, and found that these relationships encouraged the behaviours.

Malkin (1995) has argued that participation in leisure activities may provided an opportunity for personal empowerment through improved self-esteem, social interaction and amelioration of powerlessness and hopelessness that may generalise to other areas of women's lives. The comments from several participants regarding the benefit of being physically active and engaging with others, even if they were initially reluctant, supports this argument.

Pregnancy was a major turning point for a few participants, who felt that they had to make a real commitment to overcoming their depression for their child's sake.

Discussions of connectedness to others as an important factor in recovery were frequent. For some participants, it was not until friends and/or family rallied around them following their suicide attempt that they realised how much they were loved. Feeling needed was also an important aspect of this connection: in addition to the comments made by those women who became pregnant, several participants spoke of realising how much their mother needed them, leading to feeling that they could not engage in suicidal behaviour again. This feeling of being loved and needed did not necessarily have to relate to another human though – two participants talked about getting a pet as a turning point. While it seems that this connectedness could lead to cessation, it may be that in order to achieve true recovery, addressing

underlying issues may be necessary. In many cases achieving a sense of connectedness does seem to have provided the impetus for participants to seek additional help to overcome their suicidality.

Participants offered a range of suggestions for family or friends of young women who may be at risk of suicide; these have been discussed in the previous chapter.

These suggestions may be summarised as:

- Build self-esteem – demonstrate that they are loved and valuable and that you can work together to deal with the things that are troubling her. Point out her talents and skills, let her know she is appreciated.
- Communicate – provide opportunities for her to discuss her feelings in a non-judgemental way. Offer to arrange professional help and be aware that the first professional may not be the right one for her.
- Provide practical support, for example, develop a safety plan, keep her physically active, help her get through each day as it comes.
- Get support for yourself.

Control

As discussed above, issues of power and control seemed to be instrumental to recovery for most, if not all, the participants in the current study. Gaining a sense of control over their lives was a key factor in both cessation and the recovery of many participants. Participants discussed taking control through self-mutilation, which may reduce suicidal behaviour, but in order to achieve recovery participants had to learn positive coping strategies and problem-solving skills. Increased interpersonal problem-solving skills resulted in enhanced self-esteem, coping skills and an increased sense of control. These gains appeared to reduce the likelihood of repeated suicide attempts.

The research literature I have accessed touches on several concepts relating to control and powerlessness, such as hopelessness, learned helplessness, and empowerment. These concepts have been discussed in Chapter Two. The notion of hopelessness seems to have been given particular importance and is well-researched. However, researchers do not appear to have sufficiently addressed the topic of control in the sense that the participants in this study discussed it. An exception is

the work of Crockwell and Burford (1995) who discussed the importance of control, particularly in regard to relationships with counsellors and therapists in their presentation of the narratives of three female adolescent suicide attempters.

From the narratives of the participants in the current study it seems that the notion of control encompasses control of the body as well as of the emotions, developing a sense of self-mastery that goes beyond merely conquering feelings of hopelessness and helplessness.

Although regaining a sense of control may be sufficient for cessation in the short term, true recovery, as opposed to a temporary relief of behaviour and symptoms, seems largely dependent on feelings of self-worth, which may take longer to achieve. Participants discussed learning problem-solving skills, such as recognising the onset of depression, and learning to keep perspective on problems. This in turn led to feelings of empowerment and increased self-esteem. As discussed by Edwards and Holden (2001) and McLeavey, Daly, Ludgate, and Murray (1994), increased interpersonal problem-solving skills result in enhanced perceived ability to cope with problems and increased self-esteem. These gains appear to reduce the likelihood of repeated suicide attempts.

For many participants this sense of control included being reassured that their feelings were acceptable; that they were not “mental”. An obvious issue with this is that therapists may be working from the premise that the individual’s feelings are *not* acceptable – they *are* indicative of mental illness. Furthermore, in agreement with Crockwell and Burford’s (1995) research, control within the therapeutic relationship was an issue for many participants. Pressure to disclose abuse was very difficult for a number of participants to deal with, and participants also spoke of feeling pressured to deal with issues and ‘get better’.

Stigma

Insofar as a lack of self-esteem and a lack of connections to others are implicated as risk factors, addressing these issues is important in achieving recovery. A factor that may delay this process is the stigma that surrounds mental illness, as discussed in Chapter Two. Stigma was an important issue for many participants, because it

affected their self-esteem, their social relationships, and the likelihood of them seeking help.

Lapsley, Nikora and Black (2002) argued that the attitudes and behaviour of others is the most common hindrance to recovery from mental ill-health. This involves people's lack of understanding, fears, stigmatising, and rejecting behaviour. Most participants discussed stigma attached to their suicidal behaviour. For some participants this stigma resulted in them feeling ashamed and not seeking support, while others discussed being ostracised by their social group. While the studies discussed by Canetto (1997) suggested that non-fatal suicidal behaviour among females is not viewed as negatively by peers as that of males, most of the participants in the current study felt the impacts of perceived stigma. More generally, several participants spoke about the negative emotions connected with taking anti-depressant medication or being diagnosed with a mental disorder. As Lucy put it: "You don't want to believe you've got a mental problem – it's easier to believe you're a bad person or stupid", while Jackie said "Everyone I know with the label hates it ...you have the label for years...you're not an individual anymore, it's just 'how we treat the label'". Some participants felt that being labelled as mentally ill added to their burden of feeling out of control. Two participants discussed the Mental Health Foundation's 'Like Minds Like Mine' television campaign, which was current while the interviews were being conducted. This campaign features well-known New Zealanders who have had mental illnesses, most commonly depression. Both women felt that this campaign was a valuable step towards making emotional distress acceptable.

For several participants, though, the stigma attached to suicidal behaviour appears to have been positive, in that it influenced them not to repeat the behaviour. These participants spoke about the negative reactions of people in their social network to their suicidal behaviour, and as a consequence felt that they were not prepared to risk further alienation by engaging in more suicidal behaviour.

Self-Esteem

In addition to a sense of control, feeling valued seems to be important to cessation, while a key aspect of recovery is feeling valuable. There seems to be an important difference between the two. Feeling valuable can be achieved or maintained without

external reinforcement. In contrast, feeling valued is dependent on the perception of another's judgement or validation. These self-perceptions are intertwined with self-esteem and a sense of connectedness to others, the absence of which are identified in the literature as important risk factors, and correspondingly important to recovery (Overholser et al., 1995).

Summary

Most participants spoke of the importance of support in achieving recovery. For the majority this support came primarily from friends, or, less commonly, family. Most participants spoke of their family's difficulty in coping with their suicidal behaviour. In many cases their behavior was ignored, and some participants spoke of being scolded by parents. Even in cases where family members wanted to be supportive, they did not appear to know what to do, and their efforts were often hampered by feelings of guilt or shame, particularly if sexual abuse was an issue. In contrast, those who had friends available to support them found this support extremely valuable. Generally this support consisted of expressions of concern, and being available to talk to without judgement.

Some participants considered professional help to have been vital to their recovery, but they were in the minority. All participants had difficulty in accessing suitable professional help. When asked what professional help was of benefit to them, all but two participants mentioned the quality of the relationship to the professional, or the counsellor/therapists' personal attributes, rather than a specific therapy. Foremost among these qualities was a sense of control or partnership in the therapeutic process. Other qualities identified included empathy, feeling listened to, not feeling judged, feeling that the counsellor was sincere and trustworthy. Several participants discussed aversive treatment received from professionals; this was particularly common among those working within the medical system, as opposed to community-based workers. Two participants discussed specific therapies; these were dialectical behavioural therapy and narrative therapy. In addition, several participants mentioned learning problem-solving skills as being helpful. Stigma was frequently discussed as a barrier to recovery; participants were reluctant to seek help because of fear of being labelled mentally ill, and others spoke of the judgements of people in their social circle negatively impacting their self-esteem.

As discussed in Chapter Two, young people may be reluctant to seek help for depression and suicidal ideation (SPINZ, 2000; Spirito et al., 2000). Some participants in the current study did seek professional help when they became suicidal, but found this help to be insufficient to prevent their suicidal behaviour. In addition, participants sought support from family and friends (although usually after suicidal behaviour had occurred), and discussed the ways in which they changed their lives in order to recover from suicidal behaviour. While primary prevention methods were insufficient for these participants, the processes they went through in moving beyond their suicidal behaviour may provide some clues for prevention for others.

Generally speaking, the steps to recovery identified by participants involved changes to the ways participants thought about themselves in relation to others, such as feelings of being worthless, for example, and their own ability to affect their lives positively. Several participants in the current study discussed learning coping skills as important to recovery and mentioned a previous tendency to go straight to suicidal ideation when difficulties occurred in their lives; they also mentioned difficulty in maintaining perspective leading to escalating feelings of hopelessness. These comments resonate with Pollock and Williams' (2001) discussion of problem-solving skills. Pollock and Williams argued that suicide attempters tend towards dichotomous thinking, are apt to be inflexible and rigid in their thinking and often demonstrate a deficit in the ability to remember previously used successful problem-solving strategies; this, in turn, leads to difficulty in changing their problem-solving strategies. These authors suggested that recognition of these cognitive processes is important in the counselling process; skills for the development of new strategies may be an important part of the recovery process.

The lack of information about what interventions and secondary prevention measures work has been discussed in Chapter Two (Burns & Patton, 2000; Canetto, 1995; van der Sande, 1997), and is reflected in the perspectives of the women involved in the current study. For the most part, participants felt that having someone who listened to them without passing judgement was an important factor. Most participants felt that this person did not have to be a professional; more important qualities were empathy and sincerity. As discussed above, experiences

with counsellors or therapists were largely negative, particularly those working within the mental health system. Many participants spoke of feeling judged, invalidated, not feeling understood, not being believed or having their experiences minimised, and being labelled as manipulative or attention-seeking. In addition, most of those who received a psychiatric diagnosis found it unhelpful, leading to feeling 'out of control', sick, uncontrollable, and labelled – not 'normal'. Participants also spoke of feeling pressured to perform; to get better, and to disclose abuse before they felt ready to; they also felt discomfort with the pace of counselling or therapy, which left them with insufficient time to process information and realisations. Some were also concerned about friends finding out that they were seeing a counsellor or therapist. Stigma was an important factor for many participants; they spoke of being ashamed of being "mental" and some did not seek support (either professional or from friends) because of this shame. This stigma is currently being targeted by media campaigns, such as those by the Mental Health Foundation; it remains to be seen what impact this has on help-seeking behaviour and the self-esteem of depressed youth.

Primary prevention is a complex issue. Given that most of the participants attributed their suicidality largely to sexual abuse (combined with other factors), it seems logical that prevention of sexual abuse should be the starting point. This speaks to a need for fundamental changes to the status of women and children in society, and is beyond the scope of this thesis, but is discussed by Canetto (1995), Canetto (1997), Canetto, and Lester (1995) Canetto and Sakinofsky, (1998) Debold, Brown, Weseen, and Brookins (1999), Gilligan, Lyons, and Hammer (1989), Striegel-Moore and Cachelin (1999) and others. However, given the unsatisfactory experiences of almost all of the participants who sought professional help for this issue, particularly from mental health professionals such as psychiatrists and psychologists, greater awareness and training in appropriate ways of dealing with the disclosure of sexual abuse seems warranted. Several participants spoke in glowing terms of the help and support received by specialist community organisations such as Rape Crisis. Improved accessibility to these organisations may be of considerable benefit, as well as further training of people who are likely to be the first contact for young women seeking help, such as school counsellors.

Nearly half the participants were aware of suicidal behaviour by someone close to them, and several stated that this encouraged them to see suicide as a possible solution to their problems. As discussed above, suicide contagion is a recognised phenomenon. Therefore, it seems that efforts to identify those who may be at risk of contagion and arrange appropriate services would be worthwhile. This could extend to the families and teachers of those considered to be at risk, and steps towards this have been taken (Ministry of Education, 1997). Guidelines for and evaluations of the current plethora of school-based programmes aimed at increasing awareness of youth suicide seem warranted, as current research seems to suggest some of these programmes may increase the risk of suicidal behaviour (Gould & Kramer, 2001).

Participants offered several suggestions for people concerned that someone they know may be suicidal. These are given in detail in Chapter Five and involve building self-esteem, facilitating communication and practical measures. Although aimed at family members and friends, they seem equally applicable to professionals.

Summary

The prevention of suicidal behaviour is a complex issue. Many participants were dissatisfied with the interventions they encountered, and found the support of friends to be as, if not more, effective than that of mental health professionals, at least in the short term. However, most, eventually, did find a counsellor who helped them deal with the issues underlying their suicidal behaviour. This has implications for the provision of prevention strategies.

The teaching of problem-solving techniques appears to be a promising avenue for prevention and intervention, according to both the literature and the findings of this study. Counselling appears to have been useful for many participants, once the 'right' counsellor has been found; unfortunately finding this person can take some time and perseverance. Brokering services that act as advocates for people seeking help and aim to match clients to services may have a valuable role to play. Other strategies and specific therapies, such as dialectical behaviour therapy, require further evaluation. Further training for counsellors and teachers on handling suspected sexual abuse and disclosures appears to be warranted.

Teachers, friends and family members can potentially play a role in prevention through fostering self-esteem and communication. In the case of teachers, programmes such as 'Healthy Schools' and 'Health-Promoting Schools', which are projects supported by the Ministries of Education and Health provided a foundation. Suicide Prevention New Zealand has developed community information kits. Unfortunately, it seems that some of the social factors that underlie suicidal behaviour, such as lack of access to resources and dysfunctional family relationships, may also be issues for family members; this points to a need for prevention to take place at a macro-social level, to strengthen families and communities.

Comparison of Component One and Component Two Results

The previous sections of this chapter have discussed the findings of Components One and Two of the current study respectively. There were a number of differences in the perspectives of Component One informants and Component Two participants. This section discusses these differences from risk factors through to prevention.

Risk Factors

There were several risk factors that were mentioned by one component group and not by the other. In the case of some that were identified by Component One informants but not Component Two, this could be because Component One informants were discussing females who engage in suicidal behaviour as a group, whereas Component Two participants were discussing their individual experiences. That is, while Component One informants were able to observe that, as a group, young women they see are likely to be from poor families, from particular ethnic groups, or members of specific youth sub-cultures, this connection may not be salient to Component Two participants, as it seems that the link between (for example) poverty and suicidal behaviour is less direct than other risk factors.

There were several risk factors that Component Two participants identified that were given relatively limited significance by Component One informants. These were self-mutilation, exposure to suicide, sexual orientation and sexual abuse.

Only two Component One informants mentioned self-mutilation, yet nearly three-quarters of the Component Two participants had self-mutilated, and they identified explicit links between the behaviours. While there are distinctions between self-mutilation and suicidal behaviour, as discussed in Chapters Two and Five, Component Two participants identified a relationship between the two, particularly through using self-mutilation as a way of dealing with suicidal feelings. To some extent the lack of a linkage between the behaviours is in line with the psychology and psychiatry literature, which usually discusses the behaviours as separate and unrelated, although the possibility of individuals engaging in both behaviours is acknowledged.

A few Component One informants mentioned exposure to suicide as a possible risk factor. However, given that nearly half the participants in Component Two discussed the suicidal behaviour of someone in their social network as impacting their own decision to engage in suicidal behaviour, and the concerns about 'copycat' suicides in both academia (for example, Agnew, 1998) and the media, the lack of recognition of this linkage by component One informants seems rather surprising.

Sexual orientation was not mentioned by Component One informants. Although the research conducted to date on the importance of gay, lesbian and bisexual orientation as a factor for suicidal behaviour remains somewhat inconclusive, on balance it appears that non-heterosexual orientation may play a role in suicidal behaviour, but only when combined with other contributing factors (D'Augelli et al., 2001). This overall impression is confirmed by the lesbian participants in Component Two of the research: two of these three women identified their sexual orientation as a contributing factor to their suicidal behaviour, in combination with other issues that affected their self-esteem.

Most participants in both components of the research identified a history of sexual abuse as a risk factor for suicidal behaviour; this is in agreement with the research literature, as discussed at length in Chapter Two. However, the participants in the two components of the research differed in the degree of importance placed on this factor. While all participants who identified this factor felt that, in itself, sexual abuse was insufficient to 'cause' suicidal behaviour, it appeared to be both more common and more important to them than Component One informants realised. In addition,

the way disclosures of abuse are handled appeared to be of key importance to Component Two participants; this did not appear to be fully recognised by Component One participants. Several Component Two participants spoke passionately of being pressured to disclose abuse before they were ready, of having their experiences minimised, and of the distress this caused. Some women stated that the events that occurred as a result of disclosure of abuse were as stressful as the abuse itself.

Finally, Component One informants spoke of a number of disorders as risk factors for suicidal behaviour. These included borderline personality disorder, conduct disorder and substance abuse. Many Component Two participants mentioned engaging in behaviours that are considered symptoms or diagnostic criteria of these disorders, and several were in fact diagnosed with such a disorder. However, Component Two participants discussed these behaviours as coping mechanisms, behaviours that occurred as a result of other underlying factors, rather than as causal factors in themselves. There appears to be some confusion or misunderstandings about correlated and causal relationships. Indeed, Jackie recalled being told by a psychiatric ward staff-member that if she continued to self-mutilate she would “get” borderline personality disorder. While the notion that cutting herself would make her mentally ill did act as a brief deterrent, it indicates a lack of understanding of the mechanisms at work behind these behaviours.

Cessation and Recovery

Several factors were identified by informants and participants that impacted on the cessation of suicidal behaviour and recovery from suicidality. Whereas Component One informants tended to focus on their own method of intervention and treatment, Component Two participants discussed the issue of recovery more holistically. As well as discussing interventions and treatments, Component Two participants explored barriers to help-seeking and the role of family and friends in more depth.

Stigma was not discussed at all by Component One informants, but was an important issue for Component Two participants, both contributing to suicidal behaviour, in that participants were reluctant to seek help for depression and/or suicidal feelings, and as a barrier to recovery. As discussed in Chapter Two, stigma

about mental illness is a well-established phenomenon and has received attention from the psychological and psychiatric community (Lapsley, Nikora & Black, 2002; Link & Phelan, 2001, for example). It would seem reasonable to assume that Component One informants would be aware of the possible impact of stigma on their clients, either through their own training and reading of the literature or through client interactions. Therefore it is surprising that stigma was not discussed.

While some Component One informants acknowledged that family and friends of suicidal young women *could* have a positive influence, the overall impression received on this topic was rather negative. Component Two participants were generally more negative about the roles their parents had played, and more positive about the support received from friends, than Component One informants. Some Component Two participants felt that the support and nurturing received from friends was considerably more important than professional help.

Participants in both groups discussed early termination of counselling or other intervention. While Component One informants saw this as largely due to external factors such as financial difficulties or a lack of family support, Component Two participants always saw the issue as one of unsuitability of the counselling or treatment offered, in some cases coupled with concerns about the stigma of being labelled as mentally ill. 'Dropping out' of counselling seemed most likely to occur when the individual was dealing with issues of sexual abuse, and when the provider was a clinician or other member of the mental health service. It may be that the individual was not ready to commit to the counselling/therapy process and perceived this as an unsuitable approach on the part of the therapist. However, given that many participants continued to seek help until they found some-one they could work with successfully, this seems unlikely for most.

One Component One informant, a senior researcher in the field, said that she had asked hundreds of young people who had made suicide attempts what services they want and found that "they can't answer, or they tell you what they think you want to hear". Component Two participants were quite clear about the help they needed: not necessarily a 'service', but to be listened to, not judged or diagnosed, but valued. A difference between this informant's research participants and the participants in Component Two of the current study is that the former were asked these questions

within a few days of hospitalisation for suicidal behaviour, while the latter had had at least a year to reflect. Also the Component One informant's research participants may have been uncomfortable when interviewed in a mental health setting, and wished to curtail the interview, as opposed to the settings of the interviews conducted in the current study, which were more conducive to relaxed reflection.

Finally, participants differed in their view of the importance of professional help. Almost all the Component One informants considered professional help to be vital, while many of the Component Two participants felt that social support was equally important. Component Two participants also emphasised the quality of the provider-client relationship, discussing issues such as sincerity, non-judgemental attitudes and partnership in the process; only one Component One informant raised these issues. Table 9 summarises the key differences of participants in relation to therapeutic relationships.

Component One	Component Two
<p><i>Professional</i> help (counselling, therapy, medication) view as very important, but the type of help considered most beneficial varies according to philosophy; those working in mental health/medical system:</p> <p>Emphasis on</p> <ul style="list-style-type: none"> -mental illness diagnosis -biochemical processes -treating the disorder <p>focus on treating symptoms and the proximal issues</p> <p>Those working in community organisations seem more attuned to individual needs – more willing to be in a partnership with the client and address the issues as identified by the client.</p>	<p>Relative unimportance of <i>professional</i> help. Although ultimately beneficial to most, many unhelpful and adverse experiences, particularly in the mental health system. Those that were beneficial seem to be more likely to be working in community-based service, such as Rape Crisis</p> <p>Emphasis on underlying, background factors – relative unimportance of ‘triggers’ such as relationship break down</p> <p>Need to have input into counselling process</p> <p>Importance of sense of control</p> <p>Importance of feeling heard</p>

Table 9: Key differences in the perspectives of Component One informants and Component Two participants regarding interventions.

Prevention

In regards to prevention strategies, Component One informants tended to focus on community and teacher education about mental health, school-based programmes on topics such as communication skills, and increased accessibility to support services.

Component Two participants mentioned a lack of knowledge on the part of teachers as an area that could be improved, but generally spoke more about secondary

prevention. Some participants in the current study did seek help when they became suicidal, but found this help to be insufficient. In addition, appropriate support for dealing with sexual abuse was a possible prevention strategy identified by Component Two participants.

Several participants in the current study discussed learning coping skills as important to recovery and mention a previous tendency to go straight to suicidal ideation when difficulties occurred in their lives; there appeared to be difficulty in maintaining perspective and thinking of possible solutions to problems, leading to escalating feelings of hopelessness. These problem-solving skills could be expanded upon in the school curriculum.

Participants in the two components of the research did not disagree on prevention measures, and some suggestions overlapped, such as promoting communication skills within social networks. Overall the suggestions offered did differ in that Component One informants focussed on secondary prevention (for example, identifying those already at risk, rather than preventing risk) whereas Component Two participants focussed on both secondary and tertiary (preventing repetition) prevention.

As Canetto (1995) noted, the problem with treatments is that they are an ‘ambulance at the bottom of the cliff’ approach; a real reduction in rates will only come about when the nature of society changes. The most promising strategies may be those primary programmes that target social and cultural factors, such as addressing stigma and family violence; these strategies may also be the most difficult to implement, as shown by the complete absence of suggestions by participants in this regard.

Conclusion

Component One informants and Component Two participants identified a range of factors that precipitate suicidal behaviour in young women and impact cessation and recovery. They also discussed a number of prevention strategies.

Although there were many areas in common to both groups, such as the identification of family dysfunction, they differed in the emphasis placed on several aspects, such as sexual abuse and its disclosure, self-mutilation, the importance of professional help and the role of family and friends. In addition, there was marked within-group difference in Component One participants, in that those working within the mental health service tended to emphasise pathological factors and those working in community-based settings seemed more concerned with the wider context of the suicidal behaviour. The perspectives of Component Two participants generally seemed more aligned to those of community based Component One informants. Component Two participants were also concerned with issues of power and control, both in regard to suicidal behaviour and recovery; this appears to have been largely overlooked by Component One participants.

Table 10 and Table 11, below, summarise the main features of the pathways from precursors to suicidal behaviour through to recovery, from the perspectives of Component One informants and Component Two participants, as groups.

Risk factors		Cessation
<p>Biological/pathological</p> <p>Short-term (proximal)</p> <ul style="list-style-type: none"> - schooling problems - relationships <p>Environmental (distal)</p> <ul style="list-style-type: none"> - family dysfunction - sexual abuse - effects of poverty, ethnicity, etc 	<p>→Suicidal behaviour →</p>	<p>“Our” therapy/service.</p> <p>May include</p> <ul style="list-style-type: none"> - a specific therapy e.g. CBT - medication - family therapy - teaching coping skills - dealing with environmental issues, as at left, <p>Among those in the mental health service the focus appears to be on proximal and biological issues.</p> <p>Barriers to recovery</p> <ul style="list-style-type: none"> - effects of disorder - lack of commitment - being rewarded for the behaviour

Table 10: Pathways according to Component One informants.

Risk factors		cessation
<p>Environmental</p> <ul style="list-style-type: none"> - family dysfunction - sexual abuse - loss of control - social isolation <p>Biological (identified by 2 participants)</p> <p>Short-term (proximal)</p> <ul style="list-style-type: none"> - relationships 	<p>→ risk-taking/eating disorder/substance abuse/ self-mutilation/suicidal behaviour →</p>	<ul style="list-style-type: none"> - having some-one to talk to - being heard without being judged - feeling capable/in control - feeling valued - not feeling powerless/hopeless - the <i>right</i> person <p>Barriers to recovery</p> <ul style="list-style-type: none"> - stigma - not having an appropriate person available for support - inappropriate 'therapy' or 'counselling' - inappropriate meds

Table 11: Pathways according to Component Two participants.

CHAPTER EIGHT: CONCLUSIONS

This thesis has examined the phenomenon of non-fatal suicidal behaviour among young women in New Zealand. Death can increasingly be deferred through advances in medical science; we are more aware of the causes of premature death than ever before, and we are able to improve both the quality and the length of our lives. Yet some young people in New Zealand continue to attempt (and in some cases succeed) to take their own lives.

Suicidal behaviour is most common among those aged under 25. The most recent statistics indicate that 198.5 per 100,000 young people were hospitalised for deliberate self-injury in 1999/2000³⁸ (Ministry of Health, 2002). While it may be commonly perceived that males perform the majority of youth suicidal behaviour, two-thirds of the hospitalisations in the year from mid-1999 to mid-2000 were females. This equates to 698 young women and the rate of suicidal behaviour in young women is increasing, while for young men it appears to be decreasing (Ministry of Health, 2002). Moreover, figures given for hospitalisation for non-fatal suicidal behaviour do not reflect overall rates of the behaviour, which may be much higher.

Suicidal behaviour is markedly different for males and females, as has been discussed in Chapter Two. Males are far more likely to complete suicide, while females are far more likely to engage in suicidal behaviour overall, and non-fatal suicidal behaviour in particular. Females also appear to be more likely to make repeated suicide attempts (Bennett et al., 2001). This gender-differentiated behaviour is often assumed to be merely the result of the method of suicidal behaviour chosen (males are likely to use more lethal means, such as shooting, than females), and research that considers gender is relatively uncommon (Canetto, 1995).

The international literature suggested that many people who commit suicide have made a previous unsuccessful attempt, while research in New Zealand found that 52% of people who made a medically serious suicide attempt made another within 30 months (Beautrais et al., 2000). It is clear that productively addressing non-fatal

³⁸ These figures are calculated from mid-year to mid-year.

suicidal behaviour will impact completed suicide rates positively, as well as decreasing the reoccurrence of non-fatal suicidal behaviour. Despite the prevalence of non-fatal suicidal behaviour and the associated social costs, it appears from the literature I have been able to review that the research that has been conducted (particularly in New Zealand), has focused almost exclusively on risk factors, often in isolation from context, with a view to determining correlates.

When synthesised, the literature reviewed in this thesis suggests that although many young women who engage in suicidal behaviour may be clinically depressed, and some are diagnosable with other disorders, the impact of social factors is also important. A history of sexual abuse has been found in many of these women, and family difficulties are also common. In addition, some women have also been involved in other self-harming behaviour, such as eating disorders or self-mutilation. As several precursors to suicidal behaviour seem more common in females than males, such as depression and sexual abuse, it would appear that underlying reasons for suicidal behaviour differ between the genders. However, gaining a full understanding of the reasons why young women engage in suicidal behaviour and (equally importantly) why they stop, is not yet possible from reading the research reported available to date.

In this thesis I have sought to explore the experiences of women who have engaged in suicidal behaviour, and to (re)present the meanings women attribute to their experiences. The vast majority of research into suicidal behaviour, both in New Zealand and internationally, uses quantitative methods and is informed by the medical model. In contrast, this thesis has used qualitative methods of research and analysis. From the qualitative viewpoint, reality is socially constructed; no issue can be understood in isolation from its environment. The variables in each individual case are complex and interwoven. The narrative approach is particularly apt for this thesis in that it seeks to understand social impacts on behaviour; these social impacts are by definition embedded in women's experiences and interactions. This final chapter presents the main conclusions of the thesis, discusses limitations of the research and identifies areas for further research.

Component One data were gathered through interviews with key informants. In total 25 people participated, from 15 organisations. Component One informants

largely agreed on the risk factors, interventions and prevention overall. However, there was a clear divergence of opinion between two sub-groups that could be broadly categorised as clinicians/mental health service workers, and community-based workers. All agreed that most young women who engage in suicidal behaviour are diagnosable with a mental disorder such as depression, and that a number of social factors also contributed to their suicidality. However, the two groups differed over the importance of these factors. Among community-based workers, family dysfunction and sexual abuse were considered to be the most common underlying factors, with some informants also identifying youth culture, ethnicity and substance abuse. Perspectives on ethnicity varied widely in the current study, but overall more importance appears to have been placed on it than has been seen in the local literature until very recently. In contrast, mental health workers tended to focus on psychopathology, with other factors receiving rather less attention.

This divergence of opinion about the importance of psychopathology was continued into perspectives on intervention and prevention. There were two general strategies presented: determining a correct diagnosis and medicating appropriately, and addressing underlying social factors and deficits. All informants agreed that these strategies are often most effective when applied concurrently, but many felt that one strategy was far more important than the other. Additionally, no clear picture of what specific interventions were effective emerged. This could be because appropriate interventions vary according to the individual, but the impression received was that informants felt that the model or approach they were trained in was the most appropriate for most clients/patients.

Informants had relatively few comments on prevention. As with intervention, the strategies suggested tended to focus on addressing deficits, alongside some health promotion measures. These strategies were broadly in line with those supported by the literature I have reviewed.

Component Two participants were 24 women who had previously engaged in suicidal behaviour, while aged under 25. Participants identified a large number of background factors, from which themes quickly emerged. All participants in Component Two of the research discussed combinations of risk factors, although for most there were one or two that were particularly salient. All Component Two

participants spoke of family dysfunction as being a contributor to their subsequent suicidal behaviour, including two women who considered that their suicidal behaviour was primarily due to biological causes. While the divorce of parents does not seem unusually common among the participants, most spoke of finding parental conflict disturbing. Almost all participants spoke of a level of physical, emotional or sexual abuse within the family that was sufficiently severe to be considered a cause of their suicidal behaviour. Additionally, there were 5 parental deaths, two of which were suicides.

Shyness, lack of confidence or low self-esteem resulting in social isolation were considered contributing factors by approximately half the participants. This was often attributed to the effects of sexual abuse, and in some cases to 'feeling different' because of religious beliefs. In one case, social isolation appeared to have been a deliberate parental strategy to facilitate abuse. Loss of self-identity/self-esteem was mentioned by a number of participants, in several cases because of problems at school or due to sporting injuries. Other factors discussed, but which appear to have concerned relatively few participants, were sexuality, academic failure, and the influence of friends. Although repeatedly mentioned as a trigger, the break-up of intimate relationships appeared to be insufficient cause for suicidal behaviour in itself.

Suicidal behaviour in their social circle seemed quite common for the women involved in this study. Nine of the 24 participants were aware of suicidal behaviour within their family, in four cases resulting in death, and three participants were aware of suicidal behaviour in their social network, prior to their own suicidal behaviour. Awareness of the impact of suicidal behaviour on others clearly did not have an inhibitory effect.

Many participants spoke explicitly of feeling powerless or out of control of some aspect of their lives, often as a direct result of sexual abuse. This loss of control was variously sited by participants either in the body (abuse) or emotions (feeling that depression was out of control, for example). This sense of loss of control, and the need to regain control, appeared to be a very important theme; many participants spoke of acts of self-harming behaviour as a way to gain control of their emotions, body or life/death.

Sexual abuse would seem to be a very prevalent risk factor. It was more commonly reported than would be expected from statistics (Anderson, 1993; Fergusson et al., 1996; Ministry of Health, 1998; Muir, 1993); 15 of 24 participants reported sexual abuse, usually perpetrated by a family member. In addition, another participant suspects abuse that she does not remember and two more had their first sexual experiences in regretted and possibly coercive situations. Most of these participants clearly identified sexual abuse as *the* factor that had the most influence on their subsequent suicidal behaviour, although all identified other exacerbating factors. Issues around the disclosure of sexual abuse was also a particularly influential factor. A few participants did not consider that their experience of sexual abuse was the single most important impact; for these women reactions to disclosure of abuse was at least as traumatising as the abuse itself.

The overall impression is that without distal factors such as sexual abuse and family dysfunction the suicide attempt would not have occurred; the proximal factors (academic failure, relationship break-down) were insufficient cause for suicidal behaviour in themselves. All but two participants located key precursors to suicidal behaviour in interpersonal relationships. This appears somewhat at odds with the results of Component One of the research; although background factors were acknowledged by all key informants, some appeared to place the emphasis (in treatment/recovery at least) on dealing with the immediate 'triggers', or on dealing with psychopathology.

In addition to behaviour of suicidal intent, many participants engaged in self-harming behaviour which was not suicidal, such as self-mutilation, substance abuse or disordered eating. Self-mutilation was used by participants as a way of dealing with negative emotions, through changing the focus of their pain, reclaiming power over their body, and releasing tension. A wide range of emotions were associated with it; anger and frustration were the most commonly mentioned, but shame, guilt and a need to punish oneself and a need to feel strong were also discussed. Self-mutilation appears to have been more common among those with a history of sexual abuse; the severity of abuse may be related to the severity of self-mutilation, but this is unclear from the current study. Although an increased likelihood of suicidal behaviour among young women who self-harm has been discussed in the research literature I have reviewed, the behaviours are usually seen as distinct (Favazza, 1989; Walsh &

Rosen, 1988). However, the participants in this thesis clearly saw links between the behaviours. Notably, self-mutilation was frequently used as a way of dealing with suicidal feelings. Although most participants endeavoured to keep self-mutilation secret, three of the 17 who self-mutilated felt that the behaviour was an appropriate way of dealing with their feelings. These precursors are in themselves indicators of distress; they may also be indicators of potential suicidality.

Component Two participants identified a range of factors that affected cessation and recovery, such as medical interventions, medication and input from family and friends. The sense of loss of control discussed above also has implications for interventions; participants spoke of the desire for a sense of control or partnership in therapeutic relationships, which was largely missing in their experiences. Overall, participants found support from friends to be most helpful, while professional services, particularly within the mental health system, were often viewed negatively. Most participants experienced negative interactions with health professionals and counsellors, often related to disclosures of sexual abuse, or to difficulty in engaging with providers. Some participants spoke of counsellor/therapist confidentiality breaches, minimisation and disbelief of experiences, and unnecessarily aversive medical treatment. Those that did find counselling or therapy helpful stressed the importance of forming a partnership with a counsellor/therapist that they could trust, in which they felt safe, in control and not judged.

Fewer than half the participants were formally diagnosed with a mental illness. Of those that were diagnosed, all but one considered this unhelpful. Participants spoke of feeling stigmatised, labelled and treated as a disorder rather than as an individual, as a result of diagnoses. Some participants felt that the diagnosis of clinical depression and/or anxiety they received was unhelpful, given their histories of abuse; rather than this depression and anxiety being pathological, they considered it a normal (and particularly in the case of anxiety) adaptive reaction.

Support from friends was generally found to be very helpful, although this was not available to all participants. This support was often very simple: expressing concern, love and affection in a non-judgemental manner; keeping the participant physically occupied during times of crisis; allowing the participant to talk through their concerns without judgement. However, contagion or 'copy-cat' behaviour was

discussed by several participants, both resulting from peer support groups, and informal friendship networks.

In contrast to peer relationships, the response of family members, particularly fathers, was mainly negative. Several participants spoke of their suicidal behaviour being ignored, while some family members reacted with anger or embarrassment. Several participants identified their parents' concern, but these parents often seemed at a loss as to how to offer support.

Stigma was discussed by many Component Two participants. Most indicated that fear of stigmatisation acted as a barrier to help-seeking, and several commented that they continue to feel ashamed or embarrassed of their behaviour and fear being identified as 'crazy' some years after. Fear of stigma was also a factor in ceasing suicidal behaviour for some.

Many participants identified a need for support for the family and friends of young women at risk of suicidal behaviour, and felt the services currently available were inadequate. Participants also discussed a number of prevention strategies, although these focused on crisis services rather than primary prevention. Although there were many areas in common to both groups, they differed in the importance placed on several aspects, such as sexual abuse and its disclosure, self-mutilation, the importance of professional help and the role of family and friends. Group perspectives on the intention of suicidal behaviour also differed. Whereas several Component One informants spoke of suicidal behaviour as a 'cry for help', attention-seeking or manipulative behaviour, Component Two participants were usually serious in their intention to die at the time of engaging in suicidal behaviour. In addition, there was marked within-group difference in Component One participants, in that those working within the mental health service tended to emphasise pathological factors and those working in community-based settings seemed more concerned with the wider context of the suicidal behaviour. The perspectives of Component Two participants generally seemed more aligned to those of community-based Component One informants. Component Two participants were also particularly concerned with issues of power and control, in regard to both suicidal behaviour and recovery; this appears to have been largely overlooked by Component One participants. Component One informants also identified macro-social factors

such as ethnicity, unemployment and poverty, which did not appear as salient to Component Two participants. This may be because Component One informants were discussing group behaviour which was not apparent to individuals, or because the effect of macro-social factors are less direct, and therefore less identifiable by the individual. Both component groups were more forthcoming on identifying initiating factors than cessation, recovery and prevention.

From the research undertaken for this thesis it may be concluded that suicidal behaviour arises from a combination of factors. Chief among these is sexual abuse, coupled with difficulties of disclosure of abuse. Many other risk factors are inter-related, such as unemployment, poverty, physical and emotional abuse and neglect, family dysfunction and depression. The presence of protective factors, such as perceived self-efficacy, connection to parents or other adults and low family stress, appear to play an important role in the impact of risk factors. Although examining single aspects of suicidal behaviour in isolation is more manageable, it appears that the whole person and their environment needs to be considered, whether we are examining risk factors, intervention, or prevention strategies.

The fact that risk factors are embedded in the individual's social environment points to the need for an examination of the socio-political context. This is especially pertinent given the difference in suicidal behaviour and attitudes between the genders. Yet the preponderance of the research conducted in New Zealand has been limited to correlates of risk factors. When researching risk factors, determining combinations of precursors is relatively simple; the real challenge is in actualising an ecological framework in prevention, one that can impact upon risk factors that include poverty and sexual abuse, but this is beyond the scope of this thesis.

This research strongly suggests that the popular notion of female suicidal behaviour as attention-seeking or manipulative is a misconception. All of the participants in this research had been distressed for some time, in some cases for years. Most had been sexually abused and many had suffered other forms of abuse. All were serious in their desire to die, although some also engaged in behaviour that was a 'cry for help'. In some cases, there was an overlap – participants would have preferred not to die, but could see no other option for ending their distress.

Limitations of the research

It is acknowledged that some of the information gleaned from secondary sources, such as the key informants in Component One, is 'second-hand' interpretations of others' behaviour. However, this information helps to flesh out the information gathered from the other components of the research and provided a different perspective on the background to behaviour. Data source triangulation encourages a more complex picture of the phenomenon being studied (Rice & Ezzy, 1999). This secondary information also helps to develop the type of reflective process that informs further data collection, as discussed above with reference to grounded theory. Additionally, comparison of professionals' perspectives and the perspectives of those formerly engaged in the behaviour may provide useful information in itself.

Informants in Component One of the research represented mainstream and Maori-targeted services. Although services that target Pacific Island youth were also approached to take part in the research, no response was received. However, several of the mainstream participants included both Maori and Pacific youth in their clients, which may go some way to addressing a possible deficiency of the research. It is acknowledged, though, that the perceptions or knowledge-base of these informants may be different to those whose service is dedicated to the needs of Pacific Islanders.

A potential problem with the chosen method in the second component is that it is retrospective; it asks participants for their recollections of events that have occurred at least a year previously, and in some cases, more than 20 years. It is acknowledged that participants' recollections of events may not be completely accurate. However, it is hoped that this is counterbalanced by greater depth of reflection, and it is believed that participants will recall the substantive issues surrounding their suicidal behaviour and its context.

The participants in this research either spoke of their experiences of working with survivors of suicidal behaviour (in the case of Component One informants) or had previously engaged in suicidal behaviour (in the case of Component Two participants). Caution should be exercised when generalising the findings from this study to young women who complete suicide.

Further research

There are a number of topics that this research has identified as being worthy of further research. These include:

- the possible links between non-disclosure of sexual abuse and suicidal behaviour;
- the possible links between negative responses to disclosure of sexual abuse and suicidal behaviour;
- the relationship between self-mutilation and suicidal behaviour in young women;
- the possible relationship between sexual abuse and self-mutilation;
- evaluations of intervention and prevention strategies;
- further research with Maori, Pacific Island and Asian survivors of suicidal behaviour;
- comparisons of males' and females' perspectives of risk factors and interventions
- applicability of the findings of this thesis to women who have completed suicide
- gender differences in the efficacy of prevention and intervention strategies.

APPENDIX ONE: INFORMATION FOR PARTICIPANTS REGARDING THE RESEARCH: DELIBERATE SELF-INJURY: INITIATION, CESSATION AND PREVENTION – COMPONENT ONE

Purpose of the research:

New Zealand has an extremely high rate of deliberate self-injury, especially attempted suicide. This rate is differentiated by gender and ethnicity. Despite this high rate, there is little information available on young New Zealand women's (non-fatal) suicide attempts.

This research is part of a wider study, which is my doctoral thesis. The thesis examines suicidal behaviour, with a particular focus on the experiences of young (under 25 year old) women, who do not have a mental illness (other than depression). There will be a particular focus on the social networks of these young women. I hope that this research will provide valuable information about the impact of the suicide attempt, the support that young women receive after suicide attempts, and the changes that occur in their lives as a result. The research consists of two main parts; firstly gathering of contextual information from key informants, and secondly talking to women in their 20s and 30s who have previously been involved in suicidal behaviour, who are in a position to reflect back on that time and identify factors that were involved in initiating the behaviour, and what helped them 'recover'. Both components of the research will be conducted in the Auckland, Waikato and Christchurch areas. Supervision is provided by Professor Jane Ritchie, Dr Mike Hills, and Dr Neville Robertson of the Psychology Department, University of Waikato.

This first component of the research will provide an opportunity to gain a greater understanding of the background of the young women concerned, and what currently happens to these young women after their medical treatment, or they have been identified as at risk. For example, I hope to answer questions such as 'Are all people who are medically treated for a suicide attempt referred to a counsellor?' 'How many actually see the counsellor they were referred to?' 'What role do family and friends play in their recovery?' I intend to speak to key informants from a range of agencies in order to get a broad perspective; they may include representatives from

women's groups, mental health services, school counsellors, private counselling agencies and youth workers.

There are general themes that I would like to discuss. Please see the list at the end of this information sheet

Researcher – Cate Wilson:

I have a Bachelor of Arts degree in Psychology from the University of Canterbury, and a Bachelor of Social Science with First Class Honours from the University of Waikato. I am currently studying for a PhD, and a Postgraduate Diploma in Community Psychology at the University of Waikato. Over the last couple of years I have been involved in a number of research projects, most of which had a focus on youth health.

Prior to commencing university study, I was employed by several community groups as an administrator, youth & community worker, and tutor over a period of 7 years. I have also served in a voluntary capacity for several agencies working with youth and women.

The Interview Process:

In the case of organizations with more than one potential participant, it may be more convenient to arrange a group interview, if this is acceptable to the participants. However, in most cases interviews will be conducted on a one-to-one basis.

Interviews will be tailored to meet the needs of participants. It is envisaged that each interview will last one to 1½ hours, however this is negotiable. In some cases more than one interview will be necessary to obtain all the relevant information. The interviews will not be structured along direct question and answer lines; I will ask questions to guide the participant to areas of particular interest, but the process of giving information will largely be determined by the participant, as to what he/she considers to be the most important factors.

Some preparation may be required of participants – please see the list of discussion themes at the end of this information sheet. One aim of the research is to identify the social and environmental factors in deliberate self-injury in differing ethnicities.

Therefore information regarding the ethnicity of the participant's clients is required, so that these links can be made.

The interviews will be taped (with the participant's permission) and a transcript of the main points of the discussion will be made. A copy of the transcript will be returned to the participant to comment on or correct.

When the relevant chapter of the thesis is completed a summary will be provided to all participants. In addition, I will try to contact all participants when the thesis is completed, so that they can arrange to read it if they wish.

Ethical Statement:

The New Zealand Psychology Society Code of Ethics will provide ethical guidelines for the research. In addition, the research has been approved by the ethics committee of the Psychology Department of the University of Waikato, and the Waikato Ethics Committee. Names and identifying information will not be used in the research, and every effort will be made to preserve anonymity at every stage of the research process, and beyond. No one other than the researcher will have access to the raw data at any time.

Ownership of the Research:

All research data collected will remain the property of the researcher. The researcher reserves the right to publish research papers arising from the research. No identifying details will be included in any published material.

Right to withdraw:

Participation in this research is entirely voluntary. If you chose to take part you can

- a) withdraw from the research at any time;
- a) refuse to answer any questions; and
- b) ask any questions about the research and have them answered fully

Discussion Themes

Interviews will be loosely guided by general themes. These themes include:

- Demographic details of clients who have engaged in deliberate self-injury

- What would they consider to be three primary factors that may contribute to deliberate self-injury, such as
 - Background history of clients,
 - socio-economic status,
 - history of sexual, physical and emotional abuse,
 - family status,
 - schooling difficulties,
 - co-morbidity
- What would they consider to be primary factors that contribute to the cessation of self-injurious behaviour, such as
 - peer support
 - peer criticism
 - family/whanau support
 - therapy/counselling
 - change to living circumstances, e.g. family structure, income levels
- Current policy for dealing with people who self-injure (e.g. if participant is a hospital social worker, are all people who are treated for suicide attempts/deliberate self-injury automatically referred to counselling services? What is the usual duration of counselling?)
-

Contact Details:

The easiest way to contact me is by email: tcw1@waikato.ac.nz

or phone me at home: 09 235 0933

or at University: 07 838 4466 extension 6382 (you are most likely to find me here on Mondays and Tuesdays during term time)

APPENDIX TWO: INFORMATION FOR PARTICIPANTS REGARDING THE RESEARCH: DELIBERATE SELF-INJURY: INITIATION, CESSATION AND PREVENTION – COMPONENT TWO

Purpose of the research:

New Zealand has an extremely high rate of deliberate self-injury, especially attempted suicide. This rate is particularly high for young women. Despite this high rate, there is very little information available on young women's suicide attempts, and much of what is available is British or American in origin.

This research is part of my doctoral thesis. In this part of the research I would like to gather information from women in their late-teens to 30s who have previously been involved in suicidal behaviour, who are in a position to reflect back on that time and identified factors that were involved in initiating the behaviour, and what helped them 'recover'. Supervision is provided by Professor Jane Ritchie, Dr Mike Hills, and Dr Neville Robertson of the Psychology Department, University of Waikato.

This component of the research will provide an opportunity to gain a greater understanding of the experiences of women who have made 'suicide attempts'. For example, I hope to answer questions such as 'What happened after your suicide attempt?' 'Did you see a counsellor?' 'Was talking to a counsellor helpful?' 'How did your friends and family react?' 'Did they know what to do to help you?' 'What advice would you give to the family and friends of young women who attempt suicide?' I hope that people who take part in the research will welcome the opportunity to talk about their experiences, what was helpful for them, or what help they would have liked to have had. I expect that this research will provide valuable information about the impact of the suicide attempt, the support that young women receive after suicide attempts, and the changes that occur in their lives as a result. I intend to speak to a range of women in order to get a broad perspective; in the Auckland, Waikato and Canterbury areas, both in cities and country areas, and of all cultures.

Researcher – Cate Wilson:

I have a Bachelor of Arts degree in Psychology from the University of Canterbury, and a Bachelor of Social Science with First Class Honours from the University of Waikato. I am currently studying for a PhD, and a Postgraduate Diploma in Community Psychology at the University of Waikato. Prior to commencing university study, I was employed by several community groups as an administrator, youth & community worker, and tutor over a period of 7 years. I have also served in a voluntary capacity for several agencies working with youth and women.

The Interview Process:

Interviews will be tailored to meet your needs. It is envisaged that each interview will last approximately 1½ hours, however this is negotiable. In some cases more than one interview will be necessary to obtain all the relevant information. The interviews will not be structured along direct question and answer lines; I might ask questions to guide you to areas that are particularly interesting, but the process of giving information will largely be determined by you, as to what you consider to be the most important factors.

You are very welcome to bring a support person to the interview with you. If you prefer, a Maori interviewer can be arranged. Your participation in the research will be anonymous.

The interviews will be taped (if you give permission) and a transcript of the main points of the discussion will be made. A copy of the transcript will be returned to you to comment on or correct.

If I'm unable to meet with you in person because of distance, there is the option of doing the interview by phone or email, or a combination of both.

Results of the research:

When the relevant chapter of the thesis is completed a summary will be provided to all participants. I'll also try to contact you when the thesis is completed, so that you can arrange to read it if you wish. A copy of the thesis will also be held by the Suicide Prevention Information New Zealand network, in Auckland, phone 09 638 7364, or email info@spinz.org.nz

Ethical Statement:

The New Zealand Psychology Society Code of Ethics will provide ethical guidelines for the research. In addition, the research has been approved by the ethics committee of the Psychology Department of the University of Waikato. Names and identifying information will not be used in the research, and every effort will be made to preserve anonymity at every stage of the research process, and beyond - no one other than the researcher will know the names of participants in the research, and no one other than the researcher will have access to the raw data at any time.

Ownership of the Research:

All research data collected will remain the property of the researcher. The researcher reserves the right to publish research papers arising from the research. No identifying details will be included in any published material.

Right to withdraw:

Participation in this research is entirely voluntary. If you chose to take part you can

- a) withdraw from the research at any time;
- b) refuse to answer any questions; and
- c) ask any questions about the research and have them answered fully

Contact Details:

The easiest way to contact me is by email: cate@waikato.ac.nz

You can also phone me at home: 09 235 0933

APPENDIX THREE: COMPONENT ONE INTERVIEW GUIDE

Discussion themes:

[Begin with discussion of anonymity, consent and recording of interview. If necessary, ask for information on the organisations services and informant's role.]

- demographic details of clients who have engaged in deliberate self-injury
- what they would consider to be three primary factors that may contribute to deliberate self-injury, such as
 - background history of clients,
 - socio-economic status,
 - history of sexual, physical and emotional abuse,
 - family status,
 - schooling difficulties,
 - co-morbidity
- what they would consider to be primary factors that contribute to the cessation of self-injurious behaviour, such as
 - peer support
 - peer criticism
 - family/whanau support
 - therapy
 - change to living circumstances, e.g. family structure, income levels
- current policy for dealing with people who self-injure (e.g. if participant is a hospital social worker, are all people who are treated for deliberate self-injury automatically referred to counselling services?)

[Summarise key points of the discussion, ask for clarification if required, and invite elaboration]

APPENDIX FOUR: COMPONENT TWO INTERVIEW GUIDE

[Begin with discussion of anonymity, consent and recording of interview. Remind participant that she may refuse to answer questions or withdraw from the research at any time.]

Demographics:

To start off, I'd like to get some background information, if that's ok.

How old are you?

What ethnicities do you identified as?

Did you grow up in a city, town or rural area?

What was the structure of the family you grew up in, for example, single parent family, 2 parents & siblings, stepparent, fostered/ adopted?

The beginning of the behaviour:

I'd like to talk now about the background to when you began to experience suicidal feelings. Please feel free to tell me what happened according to what you think is important. I'd like to get your story, rather than relying on me asking a series of questions that might not fit what happened to you.

[Prompts:]

How old were you?

Where were you living?

What led to you harming yourself?

As well as things that happened to you shortly before, do you think there are things in your background or family situation that contributed?

The behaviour (self-injury/suicide attempt)

When you attempted suicide, what did you do?

Did you have any medical treatment?

Recovery/cessation of the behaviour

Did you have contact with services in relation to the suicide attempt(s)?

[Prompts]

counsellors, social workers etc;

What was the impact of your suicide attempt(s) on family/whanau/friends?

What support did you receive after your suicide attempt, from health services or community agencies such as counsellors?

Was that helpful? Why/why not?

Do you think there is a stigma around suicide attempt? [if yes] How did this stigma effect you?

How did your friends react when they found out? What did they do? Were they helpful?

How did your family react? What did they do? Were they helpful?

Is there anything else that helped?

Do you think anything about your family or community structure impacted your recovery?

How do you think your risk factors could have been prevented?

What advice would you give to the family and friends of young women who attempt suicide?

Is there anything else that you think is important, such as:

- relationships with family/whanau
- relationships with peers
- love relationships
- school/job/unemployment
- sexual identity
- cultural identity

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